Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL305159622M
Compliance #: HL305158943C

Date Concluded: April 28, 2025

Name, Address, and County of Licensee Investigated:
Windy Acres Long Term Care Inc.
7040 Lake Boulevard
Forest Lake, MN 55025
Chisago County

Facility Type: Assisted Living Facility with Dementia Care (ALFDC)

Evaluator's Name:
Maerin Renee, RN, Special Investigator

Finding: Substantiated, individual responsibility

Nature of Investigation:
The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

Initial Investigation Allegation(s):
The alleged perpetrator (AP) financially exploited the resident when the AP took the residents narcotic medication for her own personal use. The resident experienced continued pain because she did not receive her prescribed pain medication.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was substantiated. The AP was responsible for the maltreatment. The AP sign out the resident's narcotic pain medication, hydromorphone (Dilaudid), on multiple occasions and placed the tablets in her pocket. The AP told staff and the police she took the resident's Dilaudid for her own personal use.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement. The investigation included review of the resident record, death record, pharmacy records, facility

medication errors, personnel files, staff schedules, law enforcement report, and facility policy and procedures. Also, the investigator observed resident interactions with staff.

The resident resided in an assisted living facility memory care unit. The resident's diagnoses included breast cancer and diabetes. The resident's services included assistance with activities of daily living, housekeeping, laundry, meals, and medication management. The resident's assessment indicated the resident was vulnerable to financial exploitation.

The resident's medication administration record (MAR) indicated the resident was prescribed Dilaudid 2 milligram (mg) tablets, ½ a tablet as needed every two hours. On the MAR, highlighted in pink, were the dates and times the AP signed out the resident's Dilaudid that corresponded with facility recorded videos where the AP was observed signing out and placing the resident's Dilaudid in her pocket.

The police report indicated police reviewed the video footage and interviewed the AP. The AP said she was, "definitely not" following medication passing procedures, and what the AP did was "100% against every policy," for passing medications. The AP stated she took six of the resident's Dilaudid tablets. She took a pill one night to try and help her sleep and it did not work. The AP said she did not think the dose was high enough, so the next time she took three of the resident's Dilaudid tablets. The AP said she took the last remaining two pills she had left because she was "waiting to get a third one" but was fired before she could get it. The case was forwarded for consideration of charges for Theft and Criminal Neglect.

Video footage revealed, on eight separate occasions, the AP signing out the resident's narcotic medication and placing it in her pocket.

When interviewed, an administrator stated she reviewed video footage for an unrelated incident and witnessed the AP sign out the resident's Dilaudid and place it in her pocket. The administrator pulled up the resident's MAR to compare it with the video footage. The administrator printed out the resident's MAR and highlighted in pink all the AP's medication passes that were associated with video clips showing the AP placing the resident's Dilaudid in her pocket. The administrator filed a police report and met with the AP, who told her she did take the Dilaudid for her personal use.

When interviewed, an office assistant said the resident was on hospice care and received Dilaudid for pain management. When reviewing camera footage for an unrelated incident, she and other staff witnessed the AP sign out the resident's Dilaudid and place it in her pocket. The resident had died the previous day, so staff pulled the resident's MAR and compared them to times and days the AP did the medication pass. Staff were able to coordinate video footage with the medication passes and found eight instances where the AP placed the resident's Dilaudid in her pocket. The office assistant said the AP told her she took the resident's Dilaudid for her own use.

During a consultation, a police officer said the AP told police she took the Dilaudid. The case was forwarded to the county attorney for charges of felony theft of narcotics and criminal neglect.

In conclusion, the Minnesota Department of Health determined financial exploitation was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
“Substantiated” means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

Financial exploitation: Minnesota Statutes, section 626.5572, subdivision 9
"Financial exploitation" means:
(b) In the absence of legal authority a person:
(1) willfully uses, withholds, or disposes of funds or property of a vulnerable adult;
(2) obtains for the actor or another the performance of services by a third person for the wrongful profit or advantage of the actor or another to the detriment of the vulnerable adult;
(3) acquires possession or control of, or an interest in, funds or property of a vulnerable adult through the use of undue influence, harassment, duress, deception, or fraud; or
(4) forces, compels, coerces, or entices a vulnerable adult against the vulnerable adult's will to perform services for the profit or advantage of another.

Vulnerable Adult interviewed: No, deceased.
Family/Responsible Party interviewed: No, the resident was her own guardian.
Alleged Perpetrator interviewed: No, the AP did not respond to interview requests.

Action taken by facility:
The facility retrained staff regarding narcotic medications and filed a police report. The AP is no longer employed at the facility.

Action taken by the Minnesota Department of Health:
The facility was issued a correction order regarding the vulnerable adult’s right to be free from maltreatment.

To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

You may also call 651-201-4200 to receive a copy via mail or email.

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the

Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc:

The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Chisago County Attorney
Forest Lake City Attorney
Forest Lake Police Department
Minnesota Board of Executives for Long Term Services and Supports

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30515	A. BUILDING: _____ B. WING _____	C 04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDY ACRES LONG TERM CARE INC	7040 LAKE BOULEVARD FOREST LAKE, MN 55025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL305158943C/#HL305159622M On April 1, 2025, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 11 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL305158943C/#HL305159622M, tag identification 2360.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical,	02360		

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02360	Continued From page 1 sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual person was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		