Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL307016702M
Compliance #: HL307019991C

Date Concluded: December 11, 2024

Name, Address, and County of Licensee Investigated:
Woodcrest Assisted Living
1201 Ridgeview Ter NE
Alexandria, MN 56308
Douglas County

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

Evaluator's Name: Lena Gangestad, RN
Special Investigator

Finding: Inconclusive

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) neglected the resident by using cocaine while on duty and failing to document any care provided during the night.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. The investigation found there was insufficient evidence to determine if neglect occurred. The AP denied the allegations, and no harm occurred to the residents.

The investigator conducted interviews with facility staff members, including administrative staff, and unlicensed staff. The investigation included review of the resident's records, internal investigation documentation, incident reports, personnel files, staff schedules, policies, and procedures.

The resident #1 resided in an assisted living memory care unit. The resident's diagnoses included chronic obstructive pulmonary disease. The resident's service plan included assistance with incontinence care and safety checks every hour overnight.

The resident #2 resided in an assisted living memory care unit. The resident's diagnoses included dementia. The resident's service plan included assistance with incontinence care and safety checks every hour overnight.

The resident #3 resided in an assisted living memory care unit. The resident's diagnoses included dementia. The resident's service plan included assistance with incontinence care and safety checks every hour overnight.

The resident #4 resided in an assisted living memory care unit. The resident's diagnoses included dementia. The resident's service plan included assistance with incontinence care and safety checks every hour overnight.

One morning, a staff member discovered a straw and a white powdery substance on and inside the straw on the laundry room counter. The staff member contacted the manager, who advised using gloves to secure the materials and place them in a zip-lock bag.

According to the surveillance camera footage, the AP was seen in the kitchen looking at something on the counter. However, there was no footage showing the AP using drugs.

The police report indicated, the manager informed the responding officer an overnight staff member, who was the AP, had left the items on the counter and she wanted the substance to be tested. The police officer used a Mobile Detect field test kit, which indicated that the substance was cocaine.

During an interview, the AP stated that he did not recall whether he had worked on the night of the incident. He denied using any illegal drugs while working. He said that, if he had worked that night, his responsibilities would have included assisting residents with tasks such as toileting, ensuring their safety, and doing laundry. He also said that he was required to document all completed tasks in the system.

During an interview, the manager stated that a staff member reported finding white powder and a straw on the table. She collected the evidence and took it to the police for testing. She spoke with the AP, who denied any involvement. The manager said that, based on the camera footage, she observed the AP taking the straw and heading to the bathroom. She also noted the AP did not document any of his duties that night. The manager stated the facility did not identify any injuries or physical harm as a result of this shift. The manager stated that after careful consideration, she AP's employment was terminated.

In conclusion, the Minnesota Department of Health determined neglect was inconclusive.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or did not occur.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
“Neglect” means neglect by a caregiver or self-neglect.
(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.

Vulnerable Adult interviewed: Yes.
Family/Responsible Party interviewed: No.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility investigated the incident and terminated the AP’s employment.

Action taken by the Minnesota Department of Health:
No further action taken at this time.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30701	A. BUILDING: _____ B. WING _____	C 11/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODCREST ASSISTED LIVING	1201 RIDGEVIEW TERRACE NE ALEXANDRIA, MN 56308

(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 On November 25, 2024, the Minnesota Department of Health initiated an investigation of complaints #HL307016702M/HL307019991C. No correction orders are issued.	0 000		