Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL307028323M
Compliance #: HL307024861C

Date Concluded: June 12, 2025

Name, Address, and County of Licensee Investigated:
Campus A/L (Cottages on Forest)
811 Forest Avenue
Northfield, MN, 55057
Rice County

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

Evaluator's Name: Danyell Eccleston, 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) financially exploited four residents, Resident #1, #2, #3, and #4, when the AP stole narcotics, oxycodone and morphine tablets, from four residents' medication supply.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was inconclusive. Documentation indicated the AP removed narcotics from Resident #1, #2, #3, and #4's medication supply without documenting administration of the narcotics, however, there is not sufficient information to determine what happened to the narcotics.

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 residents' records, facility internal investigation, facility incident reports, personnel files, staff schedules, law enforcement report, related facility policy

and procedures. Also, the investigator observed a staff member administering narcotics to a resident and documenting the administration.

Residents #1, #2, #3, and #4 resided in an assisted living memory care unit. Residents #1's and #3's diagnoses included dementia, Resident #2's diagnoses included clouding of consciousness, and Resident #4's diagnoses included short term memory loss. All four of the residents' service plans included assistance with medication administration and had assessments indicating each desired the facility to manage their medications and had prescribed controlled substances the facility administered, tracked, and stored.

Narcotic logbook (a log that indicating when staff members removed narcotics from supply) and medication administration record documentation review for Resident #1, 2, 3, and 4 indicated there were occasions when the AP documented removing oxycodone and morphine from supply and did not document administration of the medications.

Review of the AP's employee file indicated the AP received training regarding medication administration, medication administration records, and narcotic control books.

During interview, a nurse stated she investigated reasons for a fall experienced by Resident #4 and noted the AP documented removing oxycodone more frequently than ordered and did not see the oxycodone documented in the resident's medication administration record. The nurse stated she reviewed the narcotic logbook for further discrepancies and noted there was a pattern of residents having more narcotics removed when the AP worked at the facility.

During interview, a second nurse stated she assisted in reviewing narcotic logs and medication administration records and found occurrences over a six-month period of the AP not documenting administration of oxycodone and morphine after removing oxycodone and morphine from supply for Resident #1, #2, #3, and #4.

During separate interviews, a nurse and two unlicensed personnel stated the AP had a positive work reputation and they did not have previous concerns regarding the AP's work performance.

During interview, family members of Resident #1, #2, #3, and #4 stated they did not have concerns regarding care provided at the facility.

During interview, the AP stated she always documented in resident narcotic logs after removing narcotic medications from residents' supply and then documented the administration in the medication administration record. The AP denied occasions when she did not document medication administrations and denied stealing medications from residents.

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

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: Resident #1: No, deceased; Resident #2: No, spoke with family; Resident #3: Yes, Resident #4: No, deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
Facility conducted and internal review, education of staff regarding narcotic log and medication administration documentation.

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
	30702	A. BUILDING: _____ B. WING _____	C 04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMPUS A/L	809 FOREST AVENUE NORTHFIELD, MN 55057

(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 April 30, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL307024861C/#HL307028323M. No correction orders are issued.	0 000		