State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL357007223M
Compliance #: HL357006883C

Date Concluded: March 3, 2026

Name, Address, and County of Licensee Investigated:
Okalee of Medina
4350 Chippewa Ct
Medina MN 55340
Hennepin County

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

Evaluator's Name: Maggie Regnier
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 residents #1, #2 and #3 when she did not give the residents their medications.

Investigative Findings and Conclusion: The Minnesota Department of Health determined financial exploitation was substantiated. The AP was responsible for the maltreatment. The AP removed medications from the residents narcotic. The AP had instances of removing narcotic medications from residents' supplies, documenting this in the narcotic book but not the electronic medication administration record (EMAR). Additionally, video footage showed the AP removing medications from the med cart but not bringing the medication to the resident(s).

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident record(s), pharmacy records, facility internal investigation, facility incident reports, personnel files, staff schedules, related facility policy and procedures Also, the investigator observed staff interactions with other staff, residents and visitors. Also, the medication administration procedures.

All three residents resided in an assisted living facility.

Resident #1 diagnoses include Alzheimer's dementia, anxiety and prostate cancer. Resident #1 service plan include assistance with all activities of daily living, including dressing, eating, toileting, transfers and medication management. Resident #1 assessment indicated the resident was unable to walk and had significant cognitive impairment and has a history of agitation and restlessness. Resident #1's medication orders included narcotics.

Resident #2 diagnoses include chronic obstructive pulmonary disease (COPD), generalized anxiety disorder, chronic pain syndrome, and congestive heart failure. Resident #2 service plan includes assistance with dressing, transferring medication management and meals. Resident #2 assessment indicates was able to ambulate with assistance and was on oxygen daily. Resident #2's medication orders included narcotics.

Resident #3 diagnoses include vascular dementia, pathological facture of left arm and high blood pressure. Resident #3 service plan includes medication management, all activities of daily living including eating, dressing and toileting. Resident #3 assessment indicate severe agitation and needed behavior management. Resident #3's medication orders included narcotics.

One day, a nurse became aware the narcotic log records did not match the electronic medical records for three residents.

An internal investigation document indicated the AP was responsible for the missing documentation for the narcotics. The internal investigation included review of video footage showing the AP did not administer the medications to the residents although the AP documented giving the medications.

The narcotic log and residents EMAR showed discrepancies in documentation only for the AP. Review of these records also showed the AP had documented correctly in both the narcotic log and EMAR in prior months.

The AP training records demonstrate the AP was trained on medication administration. This training includes documentation in the narcotic book and the EMAR. The AP signed this education acknowledging proper medication administration including proper documentation.

Timecard reports further indicated the AP punched out of work at 9 p.m. but also documented taking a medication out on the narcotic logbook at 9 p.m. for resident #1. This medication was not documented in the EMAR and video footage showed the AP did not go to resident #1 to administer the medication.

During an interview, a registered nurse (RN) stated the AP had been trained on proper documentation of medication administration. The RN also stated the AP had been disciplined for not documenting appropriately when it became known however the AP dismissed the verbal correction.

During an interview, the AP stated she was trained on correct documentation including the narcotic book and the EMAR. The AP further stated if a medication was due to be given at 9 p.m. but she was to leave at 9 p.m., the AP would let the next shift give the medication. The AP further stated she would

take the medication and give it immediately to the resident. The AP also stated the residents were frequently in the common area and that is where she gave the medications to residents.

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: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility: The facility terminated the AP and re-educated staff on the medication administration documentation requirement.

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 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
Medina City Attorney
Medina Police Department
Hennepin County Attorney

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35700	A. BUILDING: ______ B. WING ______	C 11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OKALEE OF MEDINA	**4350 CHIPPEWA COURT MEDINA, MN 55340**

(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: HL357007223M/HL357006883C On November 20, 2025 the Minnesota Department of Health initiated an investigation at the above provider, and the following correction orders are issued. The following immediate correction order is issued/orders are issued for HL357007223M/HL357006883C, 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		

Minnesota Department of Health

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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 three of three resident(s) reviewed (R1, R2, R3) were 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		