

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL397125364M
Compliance #: HL397122542C

Date Concluded: October 17, 2025

Name, Address, and County of Licensee

Investigated:

Timber Pines Assisted Living
650 Northridge Drive Northwest
Pine City, MN, 55063
Pine County

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

Evaluator's Name: Angela Vatalaro, RN
Special Investigator

Finding: Not Substantiated

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 failed to provide the resident's dose of lorazepam (controlled medication).

Investigative Findings and Conclusion:

The Minnesota Department of Health determined financial exploitation was not substantiated. There was a preponderance of evidence to support a documentation error occurred involving the resident's dose of lorazepam on the date and time in question and not a drug diversion by the AP.

The investigator conducted interviews with facility staff members, including nursing staff, unlicensed staff, and the AP. The investigation included review of the resident records, controlled medication records, shift to shift controlled medication count record, hospice records, facility internal investigation, an incident report, personnel files, staff schedules, and

related facility policy and procedures. Also, the investigator observed medication cart storage, controlled medication storage, and shift to shift controlled medication counts.

The resident resided in an assisted living memory care unit. The resident's diagnoses included depression, anxiety, and mild cognitive impairment. The resident's service plan included assistance with medication administration. The resident's assessment indicated the resident was oriented to person, place, time, and situation. The resident received hospice services.

The facility's internal investigation indicated one day the resident reported she did not receive her 10:30 p.m., medications which included a dose of lorazepam. The resident's medication administration record (MAR) indicated the 10:30 p.m. medications were missed without reason. The medication card (bubble pack) showed the AP initials indicating removal. The facility contacted the AP who stated he did not administer the resident's 10:30 p.m. medications and did not recall putting his initials on the medication cards. Narcotic log records indicated the lorazepam was signed out appropriately with the AP's signature. The resident received her next scheduled dose of lorazepam at 1:20 a.m.

The resident's MAR and hospice records indicated the resident had scheduled lorazepam at 10:30 p.m. for insomnia and anxiety. The resident also had lorazepam scheduled again at 2:00 a.m.

The AP's timecards indicated on the date in question, the AP clocked in at 1:58 p.m. and clocked out at 9:25 p.m.

The resident's MAR indicated the resident's scheduled lorazepam at 10:30 p.m., as well as her other scheduled 10:30 p.m. medications were left blank indicating the medications were not administered.

The resident's lorazepam narcotic log for the date in question indicated at 10:20 p.m. a dose of lorazepam was removed with a staff signature. During an interview, leadership stated the staff signature was the AP's.

The AP's timecards indicated the day prior, the AP clocked in at 2:01 p.m. and clocked out at 1:32 a.m. The resident's MAR indicated on that day; the AP administered the resident's 10:30 p.m. medications which included a dose of lorazepam. However, the resident's lorazepam narcotic log for that day did not indicate the AP removed the 10:30 p.m. dose of lorazepam. A review of dates and times of the resident's lorazepam narcotic log against the MAR indicated the AP's signature for the resident's lorazepam removal was the wrong date, a documentation error.

The narcotic log demonstrated the narcotic count compared to the MAR administrations were correct and there was not a missing lorazepam pill, instead an administration dose was missed.

During an interview, the AP denied he administered the resident's 10:30 p.m. medications on the date in question. The AP said he was not at work at 10:20 p.m. The AP said he had left work early that day. The AP denied ever removing the resident's lorazepam and not administering the medication to the resident. The AP also denied taking the resident's medication out of the facility.

During an interview, leadership stated staff had an hour before and an hour after scheduled medications to administer. Staff document their initials next to the bubble when they popped out a medication from a medication card (bubble pack). For controlled medications, staff sign out the medication in the narcotic log. Leadership said on the date in question the AP's initials were on the lorazepam bubble pack which indicated removal and the AP's signature was on the lorazepam narcotic log at 10:20 p.m. Leadership stated there had been no concerns raised before or after regarding the AP not providing the resident her lorazepam or concerns raised of the AP not providing controlled medications to any other residents. Leadership also said there had been no concerns raised by the resident or by any other resident stating they did not receive controlled medication by any other staff.

During an interview, the resident's family member stated the resident knew when her medications were scheduled. The family member stated the day the resident said she did not receive her 10:30 p.m. medications was the only occasion the resident had concern staff did not provide her medication.

In conclusion, the Minnesota Department of Health determined financial exploitation was not substantiated.

"Not Substantiated" means:

An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment 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;
- (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;

Vulnerable Adult interviewed: No. The resident was deceased.

Family/Responsible Party interviewed: Yes.

Alleged Perpetrator interviewed: Yes.

Action taken by facility:

The facility conducted an internal investigation, verified all other controlled substance counts were reviewed and accurate, and implemented a new shift to shift count verification form for

the medication carts. In addition, the facility had the AP complete additional training on medication administration and the facility nurse completed an additional medication administration competency skills check with medication punch cards with the AP.

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39712	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/25/2025
NAME OF PROVIDER OR SUPPLIER TIMBER PINES ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 650 NORTHRIDGE DRIVE NORTHWEST PINE CITY, MN 55063			
(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 September 25, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL397122542C/#HL397125364M. No correction orders are issued.	0 000			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE