Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H54285363M
Compliance #: H54289689C

Date Concluded: October 2, 2025

Name, Address, and County of Licensee Investigated:

Essentia Health – Homestead
115 10th Avenue NE
Deer River, MN 56636
Itasca County

Facility Type: Nursing Home

Evaluator's Name:
Katherine Barnhardt 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 R1, R2, R3 and R4 when the AP took narcotic pain medications from the resident's medication supply for personal use.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was substantiated. The AP was responsible for the maltreatment. The AP financially exploited R1, R2, and R3. The AP signed out narcotic pain medications from R1, R2, R3 and R4's narcotic logbook, however, did not sign the medications as administered to R1, R2 and R3 in the resident's electronic medication administration record. The AP admitted to taking resident narcotic pain medications for personal use.

The investigator reviewed documents, notes and interviews collected by federal survey during their investigation. The investigator reviewed resident records, pharmacy records, narcotic

logbook, facility internal investigation documents, personnel files, staff schedules, related facility policy and procedures.

R1
R1 resided in a skilled nursing facility and diagnoses included quadriplegia. R1's care plan included licensed nursing services for daily and as needed pain medication administration, monitoring and effectiveness. R1's pain assessment indicated medications were utilized as pain interventions and R1 experienced almost constant pain.

R1's narcotic logbook and electronic medication administration record included oxycodone 10 milligrams one tab every four hours as needed for pain management. R1's narcotic tracking spreadsheet indicated the AP signed out oxycodone tabs from R1's supply twenty-seven times, however, twenty-five of the doses were not documented in R1's electronic medication administration record as administered.

During a prior federal investigation, a licensed staff reported R1 had taken oxycodone for a long time and knew the taste. Federal investigator notes indicated R1 reported he thought on one or two occasions the medication he received from the AP was not his oxycodone.

R2
R2 resided in a skilled nursing facility and diagnoses included chronic multifocal osteomyelitis (inflammation of the bones). R2's care plan included nursing services for daily and as needed pain medication administration, monitoring and effectiveness. R2's pain assessment indicated R2 experienced pain "almost constantly" and frequently altered day-to-day activities due to pain.

R2's narcotic logbook and electronic medication administration record included morphine 15 milligrams one tab every six hours as needed for pain management. R2's narcotic tracking spreadsheet indicated the AP signed morphine tabs out from R2's supply eleven times, however, eleven of the doses were not documented in R2's electronic medication administration record as administered.

R3
R3 resided in a skilled nursing facility and diagnoses included osteoporosis with current fracture of left femur. R3's care plan included nursing services to administer medications as ordered and monitor pain. R3's pain assessment indicated R3 experienced pain "almost constantly", however, pain medication alleviated pain.

R3's narcotic logbook and electronic medication administration record included oxycodone 2.5 milligrams every six hours as needed for pain. R3's narcotic tracking spreadsheet indicated the AP signed oxycodone tabs out from R3's supply fourteen times, however, thirteen of the doses were not documented in R3's electronic administration record as administered.

R4
R4 resided in a skilled nursing facility and diagnoses included quadriplegia. R4's care plan included nursing services to administer medications as ordered, monitor pain daily and as needed. R4's pain assessment indicated R4 experienced pain "almost constantly" and received minimal pain relief from pain medications.

R4's narcotic logbook and electronic medication administration record included tramadol 50 milligram one to two tabs every six hours as needed for pain. The investigator found no discrepancies with R4's tramadol narcotic medication records.

A facility internal investigation indicated facility leadership met with the AP when narcotic diversion concerns were brought to facility leadership's attention. A facility internal investigation indicated a resident had reported he possibly received "fake" pain medications, because the taste, texture and size were not the same as the pain medication he usually received from the AP and the AP displayed concerning behaviors. Facility leadership completed a review of controlled narcotic medications, and discrepancies were found with the AP's narcotic medication documentation. A facility internal investigation indicated the AP was notified of the narcotic discrepancies at the meeting and initially the AP attempted to explain the medication documentation discrepancies, however, at one point in the meeting the AP told facility leadership she had taken, "only PRN" (as needed) medications and had "never taken their [residents] scheduled medications".

During interview, facility leadership stated she had two meetings with the AP, the first placed the AP on administrative leave while a drug diversion internal investigation was completed, and a second that the AP told leadership she had taken the narcotics when leadership asked the AP directly. Facility leadership stated licensed staff selected the hallway they wanted to work for their shift, and the AP would select the hallway R1, R2, and R3 resided in. Facility leadership stated it was the same hallway that had the highest concentration of as needed oxycodone and through the internal investigation a pattern developed that the AP signed more narcotics out of the narc book as needed than other licensed staff. Facility leadership stated the narcotic logbook and the electronic medication administration records didn't match. Facility leadership stated prior to this incident the facility had no complaints or concerns with the care the AP provided facility residents.

During an interview, the AP stated medication administration and documenting were some of the tasks she was responsible for as a licensed staff. The AP stated she had provided medication administration for R1, R2, R3, R4 and the administration included as needed narcotic pain medications. The AP stated the narcotic administration process started by signing a narcotic out of the narcotic logbook then click or document the setup in the resident's electronic medication record. The AP stated the final step after the narcotic medication was administered was to select the administered button in the electronic medication record that showed the medication was administered to the resident. The AP stated there were issues with connectivity of the electronic records and completion of documentation was difficult. The AP stated she had a

meeting with facility leadership about tardiness, however, did not recall concerns about medication documentation or narcotic diversion as a topic of discussion. The AP stated she had not taken any resident medications.

During an interview, unlicensed staff stated the AP supervised her when she and the AP worked the same shift. Unlicensed staff stated the AP approved as needed medication administration and was required to sign off narcotics as a second signature when the unlicensed staff administered narcotics. Unlicensed staff stated she never had concerns with the AP related to medication administration.

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: Not available
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The facility conducted an internal investigation and 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
Itasca County Attorney
Deer River City Attorney
Deer River Police Department
Minnesota Board of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **09/23/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH HOMESTEAD	**115 10TH AVENUE NORTHEAST , DEER RIVER, Minnesota, 56636**

(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) COMPLETION DATE
20000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: The Minnesota Department of Health investigated an allegation of maltreatment, complaint #H54285363M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. The following correction order is issued/orders are issued for #H54285363M, tag identification 21850.	20000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

Minnesota State Department of Health

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20000	Continued from page 1 The facility has agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul .htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "reviewed" in the box available for text. Then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.	20000		
21850	Patients & Residents of HC Fac.Bill of Rights CFR(s): MN St. Statute 144.651 Subd. 14 Subd. 14. Freedom from maltreatment. Residents shall be free from maltreatment as defined in the Vulnerable Adults Protection Act. "Maltreatment" means conduct described in section 626.5572, subdivision 15, or the intentional and non-therapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. Every resident shall also be free from non-therapeutic chemical and physical restraints, except in fully documented emergencies, or as authorized in writing after examination by a resident's physician for a specified and limited period of time, and only when necessary to protect the resident from self-injury or injury to others. This LICENSURE REQUIREMENT is NOT MET as evidenced by: The facility failed to ensure three of three resident(s) reviewed (R1, R2, R3) was free from maltreatment. 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.	21850		