Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report: H55337922M
Compliance: H55335083C, H55335084C, H55335085C

Date Concluded: March 2, 2026

Name, Address, and County of Licensee Investigated:
Lakeside Generation HCC
439 William Ave E
Dassel MN 55325
Meeker County

Facility Type: Nursing Home

Evaluator's Name: Lena Gangestad, 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 multiple residents when she diverted the resident's medications for her own use.

Investigative Findings and Conclusion: The Minnesota Department of Health determined financial exploitation was substantiated. The AP was responsible for the maltreatment. Video evidence showed the AP diverting medications from the residents' medication supply. Additionally, during an interview, the AP admitted she had done so.

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

One day the AP, a nurse, notified a nurse manager a medication card containing a tablet taped into a bubble which did not correspond with the medication labeled on the card. The nurse manager confirmed the card contained miscellaneous medications rather than oxycodone.

The facility initiated an internal investigation, including review of video surveillance footage from the medication room. Video evidence showed the AP removing pills from the medication destruction container, accessing oxycodone from a locked medication box, and replacing the oxycodone tablets with pills obtained from the destruction container. The video also showed the AP placing removed oxycodone tablets into her pockets on multiple occasions.

Three residents were identified with evidence of drug diversion.

Resident #1
Resident #1 resided in a nursing home facility and had a diagnosis of low back pain. The resident's service plan included assistance with medication administration. The medication administration record (MAR) indicated the resident was prescribed oxycodone 5 mg tablets scheduled three times daily, with one additional 5 mg tablet once daily as needed.

The oxycodone medication card for Resident #1 revealed 33 tablets remaining. Eight medication bubbles (slots 6, 10, 13, 17, 21, 27, 30, and 31) were taped. The substituted medications were identified as follows:

- Slot 6: Olanzapine 2.5 mg
- Slot 10: Hydroxyzine 25 mg
- Slot 13: Hydroxyzine 25 mg
- Slot 17: Hydroxyzine 25 mg
- Slot 21: Olanzapine 2.5 mg
- Slot 27: Hydroxyzine 25 mg
- Slot 30: Hydroxyzine 25 mg
- Slot 31: Hydroxyzine 25 mg

A review of the as-needed (PRN) medication log from June through September showed 24 PRN oxycodone tablets administered. Of these, all but one were signed out by the AP.

Resident #2
Resident #2 resided in a nursing home facility and had a diagnosis of dementia. The resident's service plan included assistance with medication administration. The MAR indicated the resident was prescribed oxycodone 5 mg tablets nightly at bedtime.

The oxycodone medication card for Resident #2 revealed one inaccurate medication. Slot #2 was taped and contained hydroxyzine rather than oxycodone.

Resident #3

Resident #3 resided in a nursing home facility and had a diagnosis of aftercare following total knee arthroplasty. The resident's service plan included assistance with medication administration. The MAR indicated the resident was prescribed oxycodone 10 mg tablets every four hours as needed.

The oxycodone medication card for Resident #3 indicated two remaining doses which were not oxycodone. Slots 3 and 4 contained amlodipine 10 mg. Those tablets were identified as follows:

- Spironolactone: 2 tablets
- Quetiapine: 1 tablet
- Baclofen: 2 tablets
- Prednisone: 1 tablet
- Escitalopram 10 mg: 1 tablet
- One additional tablet was unaccounted for

During an interview, the nurse manager stated the issue was first identified when a medication card was found to have a taped-in tablet that did not match the labeled medication. Further investigation revealed multiple narcotic medications were signed out in the narcotic log but were not documented as administered on the MAR. Additional review identified three residents' oxycodone cards containing medication bubbles secured with tape. When the facility's security camera footage was reviewed it showed the AP removing discontinued medication tablets and using them to replace oxycodone tablets in the medication cards. It was also found the AP administered a higher volume of PRN medications compared to other nurses and frequently signed only the narcotic log without corresponding MAR documentation, resulting in accurate narcotic counts but incomplete administration records.

During an interview, AP stated she had worked at the facility for approximately one year and had since been terminated. She acknowledged awareness of the medication room camera. The AP admitted she replaced oxycodone tablets for Resident #1 and Resident #2 but stated she could not recall how many times, reporting that she "lost count." She stated the replacement medications were obtained from pills lying around the medication room. The AP denied altering the medication card for Resident #3. She stated the incident was a mistake and acknowledged her actions were inappropriate.

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.
Family/Responsible Party interviewed: No, attempted but did not reach
Alleged Perpetrator interviewed: No, attempted but did not reach. Subpoena sent.

Action taken by facility: The facility initiated a medication audit and internal investigation. The AP was terminated, and the provider was notified of a potential adverse effect related to the administration of a non-prescribed medication. Multiple residents were interviewed, including three individuals for whom medication replacement was visually confirmed to be inaccurate. The local DEA office had been contacted directly.

Action taken by the Minnesota Department of Health: MDH previously investigated the issue during a standard abbreviated survey under 42 CFR 483, Subpart B, Requirement for Long Term Care Facilities, and substantiated facility noncompliance.

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

The purpose of this investigation was to determine any individual responsibility for alleged maltreatment under Minn. Stat. 626.557, the Maltreatment of Vulnerable Adults Act.

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies. 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
Meeker County Attorney

Dassel City Attorney
Dassel 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 **03/02/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeside Generations Health Care Center	**439 WILLIAM AVENUE EAST PO BOX 383, DASSEL, Minnesota, 55325**

(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 #H55337922M, 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 #H55337922M, 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 one of one resident(s) reviewed (R1) was 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.	21850		