Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL307756762M
Compliance #: HL307751288C

Date Concluded: January 29, 2025

Name, Address, and County of Licensee Investigated:
Cornerstone Residence Senior Care
421 6th Street NE
Bagley, MN 56621
Clearwater County

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

Evaluator's Name: Barbara Axness, 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), an unlicensed personnel (ULP), financially exploited a resident when she took the resident's Tramadol (a narcotic pain medication) for her own use. The AP was seen on camera footage removing Tramadol from the resident's medication box and replacing it with Tylenol.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was substantiated. The AP was responsible for the maltreatment. After being seen on camera removing Tramadol, the AP admitted to facility management that she removed the resident's Tramadol and replaced it with Tylenol and that she had been doing so for some time.

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 the resident record, facility internal investigation

documentation, personnel files, staff schedules, and related facility policies and procedures. Also, the investigator observed services provided at the facility, including medication management and medication storage practices.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia, osteoarthritis, and back pain. The resident's service plan included assistance with medication administration. The resident's assessment indicated she had a history of pain and required daily pain management.

The facility's internal investigation indicated that during an audit of medication boxes, a nurse noticed the resident's Tramadol pill looked different. The nurse compared the pill to other medications and identified it was Tylenol and not Tramadol. Facility management reviewed security camera footage and observed the AP remove pills from the medication box and replace the pills with another medication taken from the stock medication drawer. The AP was observed putting the pills she removed from the medication box into her pocket. Management interviewed the AP about the security footage and the AP said, "I have a problem, it's been going on since she started getting them, about a month later, I cannot control myself." The AP was asked by management if she had switched out the Tramadol for Tylenol each time she worked, and the AP stated that she had.

Security camera footage reviewed by the investigator showed a staff member matching the description of the AP, removing, and replacing pills from the medication cart and the narcotic medication drawer.

During an interview, facility management stated they were monitoring narcotic medication storage and use in the facility and had started completing audits, when a nurse randomly checked a medication box and noticed the Tramadol didn't look like Tramadol. After the nurse compared some medications, they realized it was a round Tylenol pill, so they began to investigate and interview people who would have had access to the medication cart. Facility management stated the AP had been a good employee and they didn't have any previous concerns with her work or that she may have been stealing narcotics. Facility management stated when they interviewed the AP, she admitted to taking the Tramadol and switching it out with Tylenol, so they terminated her employment.

During an interview, the AP admitted she had been taking the resident's Tramadol and replacing it with Tylenol, but she was unable to put a number on how many times she had done it, saying "it was a lot." The AP stated she had a history of substance abuse, and the Tramadol was "too easy" for her to access and she had "really bad self-control" and since it was just right there, she took the resident's Tramadol. The AP stated she would ingest the Tramadol while working as it helped her work better and feel like she had more energy.

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: Unable due to cognition
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The facility identified the issue after conducting a routine audit of medication set up procedures. The facility investigated the discrespency and identified an alleged perpetrator. The facility contacted law enforcement and made a MAARC report. After conclusion of their investigation, the AP was terminated.

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.

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
Clearwater County Attorney

Bagley City Attorney
Bagley Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30775	A. BUILDING: _____ B. WING _____	C 11/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORNERSTONE RESIDENCE SNR CARE	421 6TH STREET NE BAGLEY, MN 56621

(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: HL307756762M/ HL307751288C On November 27, 2024, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction order is issued. At the time of the complaint investigation, there were 26 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for HL307756762M/ HL307751288C, 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		

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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 one of one resident 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.	02360	No plan of correction is required for this tag.	