Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL407111341M
Compliance #: HL407115702C

Date Concluded: April 16, 2026

Name, Address, and County of Licensee Investigated:
The Pillars of Hermantown
4110 Lavaque Rd,
Hermantown, MN 55811
St. Louis County

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

Evaluator's Name: Brandon Martfeld, RN, BSN, 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), a facility staff member, financially exploited resident #1 and resident #2 when the AP took both resident's narcotic medications for personal use.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was substantiated. The AP was responsible for the maltreatment. There was a preponderance of evidence to support the AP diverted resident #1's Oxycodone (opioid medication used to treat severe, ongoing pain) medication and resident #2's hydromorphone (opioid analgesic used to treat moderate to severe pain) medication.

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 both resident #1's and resident #2's records, facility internal investigation, resident #1's apartment camera footage, facility camera footage, law

enforcement report, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed staff and resident interactions.

Resident #1 resided in an assisted living facility. The resident's diagnoses included dementia, osteoarthritis, and spinal stenosis. The resident's service plan included assistance with medication administration. The resident's assessment indicated the resident had as needed Oxycodone for pain, had impaired cognition, and was a vulnerable adult.

Resident #2 resided in an assisted living memory care unit. The resident's diagnoses included dementia and right shoulder pain. The resident's service plan included assistance with medication administration. The resident's assessment indicated the resident had impaired cognition, needed his medications crushed, and was a vulnerable adult.

Resident #1's medical record indicated resident #1 had an order for Oxycodone 5 milligrams (mg), take 1 tablet three times daily as needed for pain.

A facility investigation indicated a staff member noted resident #1's Oxycodone bubble pack was missing initials which indicated who gave the medication. The facility's investigation identified the AP, who signed for the administration of Oxycodone medication in the narcotic medication book at 10:55 p.m. In addition, it was identified that the AP did not notify a nurse for approval of administering the Oxycodone medication and the AP did not document that the medication was administered in resident #1's electronic medication administration record (EMAR). Call light logs and camera footage were reviewed. The camera footage revealed the AP was in another resident's room from 10:34 p.m. to 11:04 p.m. In addition, resident #1's call light log indicated the resident did not request assistance during the time the AP documented the Oxycodone was administered in the narcotic medication book.

Review of resident #1's call light log reviewed during the time and date in question indicated resident #1 did not call for assistance.

The camera footage from the hallway indicated the AP did not enter or leave resident #1's apartment during the time the AP documented in the narcotic medication book removal of Oxycodone.

The camera footage from inside resident #1's apartment lacked evidence that the AP entered resident #1's apartment during the time the AP documented in the narcotic medication book removal of Oxycodone.

Review of narcotic medication book indicated the AP removed one tablet of resident #1's Oxycodone from the medication card. However, resident #1's EMAR indicated the AP did not administered Oxycodone on the day and time.

The facility investigation was expanded to review all the residents' narcotic administration by the AP. The facility investigation indicated the AP had diverted Resident #2's hydromorphone.

The facility investigation for resident #2 indicated one day the AP was seen on camera footage dispensing two different medications into two different medication cups and then stacks the medications cups on top of each other. The medication was suspected to be resident #2's hydromorphone and Tylenol. The AP was seen on the camera footage grabbing the medication cups and two glasses of water and walked down the hallway into resident #2's apartment. Less than a minute later, the AP exits resident #2's apartment and was seen throwing out a water cup. While the AP was in resident #2's apartment, resident #2 can be seen on the camera footage sitting in the dining room. The facility investigation indicated later that evening the camera footage showed the AP removing resident #2's second dose of hydromorphone from the bubble pack and placing the medication into a medication cup. The AP was then seen walking down the hallway into a different resident's apartment, this resident's medication was documented as administered approximately 45 minutes prior to the AP walking into that resident's room. The facility investigation indicated the camera footage showed while the AP was in the other resident's room with resident #2's medication, resident #2 was sitting in the dining room. The AP was then seen on the camera footage exiting the other resident's apartment, walking back to the medication cart, where she grabbed yogurt and brought it to resident #2. The AP was then seen walking away from resident #2. The facility investigation indicated if the yogurt had resident #2's medication in it, then the AP was expected to stay with resident #2 through the duration of the medication administration.

Resident #2's medical record indicated resident #2 had an order for hydromorphone 2 mg tablet, take one tablet by mouth every two hours as needed. Review of resident #2's narcotic medication book indicated the AP signed out resident #2's hydromorphone medication at 3:50 p.m. and then documented the medication as administered in resident #2's EMAR at 6:51 p.m.

Resident #2's narcotic medication book indicated 12 days later, the AP signed out resident #2's hydromorphone at 6:20 p.m. Resident #2's EMAR lacked evidence the hydromorphone medication was administered.

Resident #2's narcotic medication book indicated six days later, the AP signed out resident #2's hydromorphone at 2:40 a.m. Resident #2's EMAR lacked evidence of the hydromorphone medication was administered.

Resident #2's narcotic medication book indicated two days later, the AP signed out resident #2's hydromorphone at 8:05 p.m. Resident #2's EMAR lacked evidence of the hydromorphone medication was administered.

Resident #2's narcotic medication book indicated 14 days later, the AP signed out resident #2's hydromorphone twice, once at 3:35 p.m. and again at 8:12 p.m. Resident #2's EMAR lacked evidence that the hydromorphone medication was administered at 3:35 p.m.

Review of the narcotic medication book indicated the AP was the only staff member over a three-month time frame to sign out resident #2's hydromorphone.

During an interview, facility leadership stated an audit was completed once resident #1's Oxycodone was found to have incomplete documentation. The facility investigation was expanded to look at all narcotic medication administration completed by the AP. Resident #2 was found with incomplete documentation for his hydromorphone that was administered by the AP. Leadership stated the process for staff to give as needed narcotics would be to report signs and symptoms of pain to a nurse and obtain permission to give narcotic medication. Once staff was given permission by the nurse, staff would remove the medication card from the locked narcotic box, initial and date the dose removed from the medication card, and document in the narcotic medication book the amount of narcotic medication remaining. Staff would administer the medication to the resident, and sign the medication as given in the resident's EMAR. The AP did not notify the on-call nurse for permission to administer narcotic medications and did not document correctly in resident #1's and resident #2's EMAR. The AP would document in resident #1's and resident #2's narcotic medication book so that the count appeared to be correct when shift to shift count was completed. A meeting with the AP was scheduled; however, the AP did not attend and did not reply to facility leadership. Facility leadership stated there was no concern with resident #1 and resident #2's pain after the incident.

During an interview, resident #1's family member stated the resident's Oxycodone was schedule for one time a day in the morning for pain. The resident would sometimes request an as needed Oxycodone in the afternoon. The family member stated it would be odd for resident #1 to request an Oxycodone so late at night, as she is normally sleeping.

During an interview, resident #2's family member stated that resident #2 does not have any pain and will deny having pain when asked.

The AP did not respond to interview requests.

The law enforcement report indicated an attempt to contact the AP was not successful.

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:

(a) In breach of a fiduciary obligation recognized elsewhere in law, including pertinent regulations, contractual obligations, documented consent by a competent person, or the obligations of a responsible party under section 144.6501, a person:
(1) engages in unauthorized expenditure of funds entrusted to the actor by the vulnerable adult which results or is likely to result in detriment to the vulnerable adult; or
(2) fails to use the financial resources of the vulnerable adult to provide food, clothing, shelter, health care, therapeutic conduct or supervision for the vulnerable adult, and the failure results or is likely to result in detriment to the vulnerable adult.
(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. Unable to interview Resident #1. Resident #2 unable to complete interview due to cognition.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: No. Did not respond to subpoena.

Action taken by facility:
The facility provided staff education regarding medication diversion and changed the process that two staff are required to complete narcotic medication administration. The AP is no longer employed by 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
St. Louis County Attorney
Hermantown City Attorney
Hermantown Police Department
Drug Enforcement Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40711	A. BUILDING: _____ B. WING _____	C 03/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PILLARS OF HERMANTOWN	4110 LAVAQUE ROAD HERMANTOWN, MN 55811

(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: #HL407111341M / #HL407115702C On March 2, 2026, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 129 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL407111341M / #HL407115702C, 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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40711	A. BUILDING: _____ B. WING _____	C 03/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 two of two residents reviewed (R1 and R2) 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		