

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL200774442M
Compliance #: HL200778808C

Date Concluded: August 12, 2025

Name, Address, and County of Licensee

Investigated:

Brookstone Manor
722 North Pokegama Avenue
Grand Rapids, MN, 55744
Itasca County

Facility Type: Assisted Living Facility (ALF)

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 facility neglected resident #1 and resident #2 when staff failed to provide sufficient supervision. As a result, there was a resident-to-resident altercation. Resident #1 sustained a fractured nose.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined neglect was not substantiated. At the time of the incident, staff were providing supervision and services according to both residents' plan of care. Resident #1 and resident #2 had no known history of physical altercations or physical aggression with residents.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of both residents' records, resident #1's hospital records, facility internal investigation, facility incident report, staff schedules, law enforcement report, related facility policy and procedures. Attempts to view

recorded camera footage was unsuccessful. Also, the investigator observed the facility, observed resident #2, and staff interactions with residents.

Resident #1 resided in an assisted living facility. The resident's diagnoses included mental health conditions. The resident's service plan included assistance with safety checks once per shift three times daily, and redirection as needed. The resident's assessment indicated she walked short distances in her room independently and used a motorized wheelchair for long distances. The resident was disoriented to time. The resident clearly communicated needs and concerns to staff. The resident's vulnerability assessment indicated the resident had impaired judgement and poor problem-solving skills.

Resident #2 resided in an assisted living facility. The resident's diagnoses included Wernicke-Korsakoff Syndrome (brain and memory disorder.) The resident's service plan included assistance with safety checks once per shift three times daily, and redirection as needed. The resident's assessment indicated the resident walked independently, was oriented to person, place, time. Resident #2 was occasionally disoriented due to his diagnoses of Wernicke-Korsakoff Syndrome. Resident #2 exhibited behaviors of gathering cups, soda pop bottles, glasses, and lining items up in a collection in his room.

The facility's incident report and internal investigation indicated camera footage without audio showed resident #1 blocking resident #2 from obtaining a coffee cup in the public area. Both residents appeared to be arguing. Resident #2 raised his arms several times and struck resident #1 three times using a coffee cup. Emergency medical services were contacted. Resident #1 sustained a nose fracture. Resident #2 did not recall the altercation or remember hitting resident #1.

Resident #1's hospital records indicated resident #1 sustained a bruise to the bridge of her nose, a left nasal bone fracture, and a superficial abrasion. Resident #1 discharged back to the facility the same day in stable condition.

Resident #1 and resident #2's scheduled services indicated both residents received scheduled services according to their plan of care.

During an interview, unlicensed personnel stated resident #1 approached the unlicensed personnel with a bloodied face and said resident #2 hit her in the face with a coffee cup. Unlicensed personnel stated they applied gauze to resident #1's nose, called leadership, emergency medical services, the nurse on-call, and kept the two residents separated. Unlicensed personnel spoke to resident #2 after the incident. Resident #2 said he did not remember the incident or remember hitting resident #1 with the cup. Unlicensed personnel stated earlier in the shift she had seen both residents' multiple times and said there was nothing different or abnormal going on with either resident.

During an interview, leadership stated the game room was a communal space open to all residents at any time. In the game room was a coffee bar which had coffee and coffee mugs for resident use. Resident #2 had a pattern of behavior that included obtaining coffee mugs from the coffee bar and collecting them in his room. One day, there was a physical altercation between both residents. Leadership stated recorded camera footage showed resident #1 in her electronic wheelchair in front of the coffee bar. Resident #2 approached the coffee bar with a coffee cup in hand. Resident #2 moved her electric wheelchair in a manner that cut off and interrupted resident #2's access to the coffee bar. Leadership stated a conversation or argument ensued. Resident #2 waved his arm in the air holding the coffee cup in a pre-punching motion and struck resident #1 in the nose and again in the face and head. Leadership stated after the physical altercation, resident #1 and resident #2 both exited the area in opposite directions.

During an interview, a nurse stated prior to the incident, resident #2 had no known history of physical altercations with resident #1 or with any other residents. The nurse stated after the incident, both residents were assessed, providers were updated, and interventions were added. The nurse spoke to both residents. Resident #1 told the nurse she tried to prevent resident #2 from taking the coffee cups before the physical altercation occurred. The nurse stated resident #2 did not recall the physical altercation. The nurse stated resident #2's physical aggression towards residents was a change in behaviors from his baseline. The facility was working with resident #2's care team in coordinating different placement.

In conclusion, the Minnesota Department of Health determined neglect 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.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17

“Neglect” means neglect by a caregiver or self-neglect.

(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:

(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and

(2) which is not the result of an accident or therapeutic conduct.

Vulnerable Adult interviewed: Yes, resident #2. Unable to reach resident #1.

Family/Responsible Party interviewed: Yes, except no family member identified for resident #1.

Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:

The facility staff kept both residents separated and called emergency medical services. Assessments were conducted, resident #1 and resident #2 providers were updated. The facility added additional safety checks and weekly mental health visits for both residents.

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: 20077	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/31/2025
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NAME OF PROVIDER OR SUPPLIER BROOKSTONE MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 722 NORTH POKEGAMA AVENUE GRAND RAPIDS, MN 55744
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(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	<p>Initial Comments</p> <p>On July 31, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL200778808C/#HL200774442M. No correction orders are issued.</p>	0 000		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____