Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL201872007M
Compliance #: HL201873636C

Date Concluded: May 30, 2025

Name, Address, and County of Licensee Investigated:
Brainerd Carefree Living
2723 Oak Street
Brainerd, MN 56401
Crow Wing County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Barbara Axness, RN
Special Investigator

Finding: Inconclusive

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, an unlicensed personnel at the facility, sexually abused the resident when she engaged in a relationship with the resident.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was inconclusive. Conflicting accounts of the incident were provided and both the AP and the resident denied having an inappropriate relationship.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement and the case worker. The investigation included review of the resident record, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed the resident's room at the facility.

The resident resided in an assisted living facility. The resident's diagnoses included post traumatic stress disorder, depression, and chronic obstructive pulmonary disease. The resident's service plan included assistance with medication administration and behavior interventions. The resident's assessment indicated the resident had mental health concerns and was alert and oriented with no cognitive impairments.

The complaint document indicated a staff member was terminated due to alleged sexual contact with a resident.

Facility records included a letter addressed to the resident which indicated findings were "After careful and comprehensive review, the investigation has concluded that the allegations of sexual misconduct are unfounded. No credible evidence was identified to substantiate the claims made against R1 [resident] and E1 [alleged perpetrator]. In addition, both parties have dismissed the investigation as 'defamation.' Based on these findings, as such, no further action will be taken in this matter."

The AP's employee record indicated she was terminated for unrelated reasons prior to the allegation being brought forward.

Multiple unlicensed personnel were interviewed. Several stated they had not heard of any allegations of staff having an inappropriate relationship with a resident and several stated they had heard rumors of a staff member and a resident having a sexual relationship. One staff member reported she had heard the resident put his finger in the AP's vagina but couldn't recall who she had heard it from. Another staff member stated she heard the AP was sleeping with the resident but also couldn't recall where the allegation originated.

During an interview, the AP stated she never had any kind of inappropriate or sexual relationship with the resident. The AP stated she was one of the only employees who took the time to sit and talk to residents. The AP stated the facility nurse was telling people she had an inappropriate relationship with the resident after she was terminated.

During an interview, the resident stated he had never had an inappropriate relationship with the AP and that the facility's nurse had made up the allegation. The resident stated the AP was very caring and supportive and had helped him with his post traumatic stress disorder and they never had an inappropriate relationship.

The resident's power of attorney (POA) stated the facility had not told her about any of the allegations and only found out after the resident told her. The POA stated she had observed the AP and the resident interact with each other and didn't see anything inappropriate and felt the AP just had a really big heart and was looking out for all her residents. The POA stated she did not believe any sort of inappropriate relationship had occurred between the resident and AP.

In conclusion, the Minnesota Department of Health determined abuse was inconclusive.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or did not occur.

Abuse: Minnesota Statutes section 626.5572, subdivision 2.
"Abuse" means:
(a) An act against a vulnerable adult that constitutes a violation of, an attempt to violate, or aiding and abetting a violation of:
(1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224;
(2) the use of drugs to injure or facilitate crime as defined in section 609.235;
(3) the solicitation, inducement, and promotion of prostitution as defined in section 609.322; and
(4) criminal sexual conduct in the first through fifth degrees as defined in sections 609.342 to 609.3451.
A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.
(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:
(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;
(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening; or
(3) use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion, including the forced separation of the vulnerable adult from other persons against the will of the vulnerable adult or the legal representative of the vulnerable adult unless authorized under applicable licensing requirements or Minnesota Rules, chapter 9544.
(c) Any sexual contact or penetration as defined in section 609.341, between a facility staff person or a person providing services in the facility and a resident, patient, or client of that facility.
(d) The act of forcing, compelling, coercing, or enticing a vulnerable adult against the vulnerable adult's will to perform services for the advantage of another.

Vulnerable Adult interviewed: Yes
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The facility interviewed the resident and AP and completed an internal investigation. The AP was terminated for unrelated concerns prior to management learning of the allegations.

Action taken by the Minnesota Department of Health:
The facility was found to be in 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

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

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20187	A. BUILDING: _____ B. WING _____	C 05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRAINERD CAREFREE LIVING BY OXFORD LI	2723 OAK STREET BRAINERD, MN 56401

(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: #HL201872007M/ #HL201873636C On May 6, 2025, 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 53 residents receiving services under the provider's Assisted Living license. The following correction order is issued for #HL201872007M/ #HL201873636C, tag identification 0620.	0 000		
0 620 SS=D	144G.42 Subd. 6 (a) / 626.557, Subd. 3 Compliance with requirements for reporting ma (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and	0 620		

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0 620	Continued From page 1 implement a written procedure to ensure that all cases of suspected maltreatment are reported. The requirement in Minnesota Statute section 626.557, Subd. 3 is: (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this	0 620		

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0 620	Continued From page 2 subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) suspected maltreatment for one of one residents (R1) reviewed for maltreatment. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The licensee failed to immediately report suspected abuse after learning of allegations of a staff member having an inappropriate sexual relationship with a resident.	0 620		

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0 620	Continued From page 3 A complaint document indicated a staff member was terminated after alleged sexual contact with a resident. Facility records included a letter addressed to the resident dated April 10, 2025, regarding an investigation initiated on April 3, 2025. The findings were "After careful and comprehensive review, the investigation has concluded that the allegations of sexual misconduct are unfounded. No credible evidence was identified to substantiate the claims made against R1 and E1 [alleged perpetrator]. In addition, both parties have dismissed the investigation as 'defamation.' Based on these findings, as such, no further action will be taken in this matter." The letter was signed by regional director (RD)-A and indicated the investigation was conducted by RD-A and the regional director of clinical services, RD-B. The facility's internal investigation included only a list of staff interviewed and did not contain details of the interviews or when the interviews were completed. The investigation indicated 13 of 14 staff members interviewed were not aware of any allegations of an inappropriate relationship between a staff member and resident. On May 8, 2025, at 11:20 a.m., Brainerd police confirmed the facility had not called or made any reports related to the resident having an allegedly inappropriate relationship with a staff member. On May 8, 2025, at 11:30 a.m., R1's power of attorney stated she was never notified by the facility of the allegations and only found out after the resident told her. On May 8, 2025, at 11:50 a.m., RD-A stated he had initiated an investigation and spoke with	0 620		

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0 620	Continued From page 4 several staff members and the resident and he thought that the regional director of clinical services had put the report together and submitted it. RD-A stated it was normally their process to make a MAARC report but with this case, he was working on the investigation and the regional nursing director was responsible for making the report and he did not follow up to make sure it was submitted. On May 8, 2025, at 12:20 p.m. regional director of clinical services/registered nurse (RD)-B stated they were first made aware of the allegations during a routine state survey and an investigation was initiated. RD-B stated she did not make a MAARC report or notify police but they were later contacted by the county so she assumed someone had made a report. RD-B stated their investigation determined the allegations were not substantiated so a report was not done afterwards. The licensee's Vulnerable Adult Reporting and Investigation policy dated April 15, 2023, indicated any sexual contact or penetration between a facility staff person or a person providing services in the facility and a resident, patient, or client of the facility would be considered reportable. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		