Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL201874807M
Compliance #: HL201871013C

Date Concluded: August 18, 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:
Katherine Barnhardt 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 the resident when facility staff did not follow the plan of care or provide proper transfer equipment to meet the resident's needs.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Facility staff followed the plan of care and implemented alternatives to meet the resident's needs while the facility waited for delivery of a larger size mechanical lift body sling. An early-stage coccyx (tailbone) wound that appeared was treated, healed and had not reopened.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted an outside staffing agency and resident representative. The investigation included review of the resident record, pharmacy records, facility internal investigation, facility incident reports, personnel files, staff schedules,

and related facility policy and procedures. Also, the investigator observed unlicensed staff provide direct resident cares.

The resident resided in an assisted living facility. The resident's diagnoses included diabetes type II and chronic kidney disease. The resident's service plan included assistance with transfers, incontinence care, repositioning and wound care. The resident's assessment indicated the resident was alert and oriented, made her needs known, summoned staff with a call pendant and depended on staff for repositioning and transfers. The resident utilized a mechanical sling lift for transfers and a manual wheelchair for ambulation.

The resident's record indicated the resident was hospitalized during the winter for a foot surgery and required a mechanical lift for transfers. The resident often declined to get out of bed when the mechanical lift was necessary for transfers and the resident's coccyx skin began to breakdown. The resident's services were adjusted to implement every two-hour repositioning, every three-hour incontinence assistance and wound care to the coccyx region. The resident had a fear of the mechanical lift and reported the body sling was too small. Licensed staff reached out to a resident representative and a larger sling was ordered and delivered. When the larger sling was delivered, the resident's services were adjusted a second time and facility staff were directed to encourage the resident to get out of bed to attend meals in the main dining room rather than meals in bed. The resident's coccyx area was monitored by a rounding provider, licensed and unlicensed facility staff. When the coccyx wound appeared it was monitored, treated and interventions to prevent reoccurrence were put in place.

A rounding provider's wound tracking document indicated the wound healed with treatment, was monitored for reoccurrence over a three-month period and remained healed.

Facility training records indicated facility staff had completed the required mechanical lift training.

During an interview, unlicensed staff stated response time to call pendants is "fast as I can" and staff communicate with walkie talkies if one is unable to get to it right away. Unlicensed staff stated the resident will report something hurts and more times than not will not want to get out of bed. Unlicensed staff stated he did not think there was an issue with the previous mechanical lift sling and the resident just "likes to stay in bed". Unlicensed staff stated barrier cream is used with incontinence cares and services are in place to prevent reoccurrence.

During an interview, licensed staff stated the resident preferred to stay in bed putting herself at risk for pressure sores. Licensed staff stated staff encouraged the resident to get out of bed to prevent reoccurrence of a coccyx wound that had started and healed before the licensed staff was hired several months earlier. Licensed staff stated she had addressed all the resident's concerns about mechanical lift transfers and had moved the resident to an apartment without carpet for ease of lift movement. Licensed staff stated the resident was better about getting out

of bed now with the interventions, however, would prefer to stay in bed without staff encouragement.

During an interview, an outside representative stated she worked with the resident for a short time and had assisted with getting the resident a larger sized mechanical lift body sling. The representative stated she was unsure of the resident's bathing status, however, thought facility staff were "washing her up" prior to the arrival of a new body sling. The representative stated she had no current knowledge of the resident.

During an interview, the resident stated the coccyx wound was "quite a while" ago, was healed but remained tender. The resident stated she preferred to stay in bed for meals and "wouldn't mind getting up once in a while". The resident stated she received bathing services twice weekly and sometimes preferred not to use pressure reducing pillows. The resident stated she preferred facility staff responded quicker to the call pendant; however, she felt safe at the facility.

During the investigation, the investigator reviewed the resident's glucose checks and found no lapse in monitoring. The investigator reviewed the resident's call pendant access and observed the resident's working call pendant at bedside.

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
Family/Responsible Party interviewed: N/A
Alleged Perpetrator interviewed: N/A

Action taken by facility:
The facility monitored and treated the coccyx wound when it appeared and implemented interventions to prevent reoccurrence when the wound healed.

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 08/12/2025

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 LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.01 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL201874807M/#HL201871013C On August 12, 2025, 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 50 residents receiving services under the assisted living license. The following correction orders are issued for #HL201874807M/#HL201871013C, tag identification 0510, 0730, 1290 and 1620.	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.	
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and	0 510		

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0 510	Continued From page 1 maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure infection control standards were followed for hand hygiene for one of two unlicensed personnel (ULP)-D. This had the potential to affect all residents and staff. 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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 12, 2025, at 10:05 a.m., the investigator observed ULP-D enter R1's room and apply disposable gloves. ULP-D removed a soiled brief, utilized incontinence wipes, applied barrier cream and put a clean incontinence brief on R1. ULP-D removed the soiled gloves and	0 510		

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0 510	Continued From page 2 disposed of them in a receptacle bin. ULP-D exited the room, touching the door knob, walked to a medication cart and drank from an open soda can located on top of the medication cart. ULP-D left the medication cart and went to an elevator where she used a touch button to summon the elevator. ULP-D exited the elevator, walked to a shared office and began documenting on a laptop shared by all ULP's. ULP-D failed to perform hand hygeine after completing R1's tasks. The investigator asked ULP-D if she had washed her hands or had hand sanitizer on her person, ULP-D stated she had not and normally she would have had hand sanitizer on her, however, "did not have it today". On August 12, 2025, at 11:58 a.m., clinical nurse supervisor (CNS)-B stated all staff are trained on proper hand hygiene, and staff are to wash hands or use hand sanitizer after the removal of gloves and after every resident. The licensee's Infection Control Precautions Including Standard, Contact, Droplet and Airborne policy dated September 11, 2018, indicated all staff would wash hands after touching blood, bodily fluids, feces or contaminated items, before putting on gloves, immediately after gloves are removed, and between tasks on the same resident to prevent cross-contamination of different body sites. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 510		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record	0 730		

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0 730	Continued From page 3 Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and	0 730		

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0 730	Continued From page 4 any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure resident records included documentation of services provided for one of one resident (R1). 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: Review of R1's medical record indicated R1's diagnoses included diabetes type II and chronic kidney disease. R1's Service Plan dated February 13, 2025, indicated R1's services included medication administration, glucose checks, transfers, bathing, grooming, dressing, wound care, safety checks, laundry and housekeeping. R1's Service Checkoff List dated June 2025, indicated the following: - June 19, 23, 26, 30, 2025, respectively,	0 730		

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0 730	Continued From page 5 indicated R1 did not receive four out of nine bathing services. R1's Service Checkoff List dated July 2025, indicated the following: - July 3, 7, 10, 14, 17, 2025, respectively, indicated R1 did not receive five out of nine bathing services. R1's records lacked documentation of the services noted above, or the reason why the service was not provided to R1. On August 12, 2025, at 11:58 a.m., clinical nurse supervisor (CNS)-B stated everything done for a resident should be documented. CNS-B stated R1 refuses services and staff are unable to make R1 shower or bath. CNS-B stated bed baths were provided for R1, however, "if it's not documented, it wasn't done". The licensee's Content of Client Record policy dated August 3, 2022, indicated the resident record would include all records of communication pertinent to the resident's services and documentation that services were provided as identified in the service plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section	01290		

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01290	Continued From page 6 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study was submitted and received for five of five employees (unlicensed personnel (ULP)-E, F, G, H, I) and was affiliated with the assisted living license for five of five employees (ULP-E, F, G, H, I). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-E ULP-E worked the following shifts: - June 4, 25, 2025, 10:00 p.m. to 6:30 a.m. - July 1, 2025, 6:00 a.m. to 2:30 p.m. - July 12, 13, 15, 2025, 10:00 p.m. to 6:30 a.m. - August 1, 2025, 6:00 a.m. to 2:30 p.m.	01290		

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01290	Continued From page 7 - August 2, 2025, 6:00 a.m. to 10:30 p.m. ULP-E's record lacked documentation of a background study completed or affiliated with the facility's assisted living license. ULP-F ULP-F worked the following shifts: - July 5, 6, 16, 19, 25, 2025, 2:00 p.m. to 10:30 p.m. ULP-F's record lacked documentation of a background study completed or affiliated with the facility's assisted living license. ULP-G ULP-G worked the following shifts: - June 1, 2025, 6:00 a.m. to 2:30 p.m. - June 7, 2025, 6:00 a.m. to 10:30 p.m. - July 19, 20, 2025, 6:00 a.m. to 2:30 p.m. - August 9, 2025, 10:00 p.m. to 6:30 a.m. - August 10, 2025, 2:00 p.m. to 10:30 p.m. ULP-G's record lacked documentation of a background study completed or affiliated with the facility's assisted living license. ULP-H ULP-H worked the following shift: - June 3, 5, 2025, 6:00 a.m. to 2:30 p.m. - July 2, 2025, 6:00 a.m. to 2:30 p.m. ULP-H's record lacked documentation of a background study completed or affiliated with the facility's assisted living license. ULP-I ULP-I worked the following shifts: - July 2, 3, 12, 15, 16, 2025, 6:00 a.m. to 2:30 p.m.	01290		

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01290	Continued From page 8 - July 5, 20, 2025, 2:00 p.m. to 10:30 p.m. - August 2, 3, 10, 2025, 2:00 p.m to 10:30 p.m. - August 11, 2025, 10:00 p.m. to 6:30 a.m. ULP-I's record lacked documentation of a background study completed or affiliated with the facility's assisted living license. On August 12, 2025, at 1:52 p.m., licensed assisted living director (LALD)-A stated all staff on the schedule provided to the investigator picked up shifts at the facility through a temporary staffing agency the last 6 to 9 months. On August 15, 2025, at 2:32 p.m., LALD-A stated she was unable to provide hire dates as requested by the investigator because she was unsure of when the staff started and didn't know where to look for the information. LALD-A stated she reached out to the staffing agency via email today when she reviewed the investigators second request for hire dates and two days after the first request. The licensee's Background Studies policy dated August 1, 2021, indicated licensee would use NetStudy and initiate a background study on all employees being considered for hire. Once an approved background study has been received, staff may act independently with residents, assuming all other requirements have been met and copies of completed backgrounds would be kept in individual employee records. The licensee's Temporary and Contracted Staff policy dated June 2021, indicated supplemental staff would only be used if they met the same requirements required as hired employees and would be treated as if they were staff of the facility.	01290		

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01290	Continued From page 9 No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days.	01290		
01620 SS=G	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part	01620		

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01620	Continued From page 10 of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to conduct a comprehensive reassessment for one of one residents (R1) with a leg wound. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident), 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: Review of R1's medical record indicated R1's diagnosis included Diabetes type II.	01620		

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 08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01620	Continued From page 11 R1's Service Plan dated February 13, 2025, indicated R1's services included medication administration, glucose checks, transfers, bathing, grooming, dressing, wound care, safety checks, laundry and housekeeping. R1's most recent assessment was completed on June 9, 2025. R1's Progress Notes dated June 3, 2025, through August 8, 2025, did not include a note about R1's left leg wound. R1's Individual Treatment and Therapy Management Plan dated June 9, 2025, did not address the leg wound. R1's Bathing/Shower Service Received document dated February 3, 2025, through August 7, 2025, indicated no documentation about a left leg wound. R1's bathing/shower task included instructions for skin checks and report changes in skin to a nurse. On August 12, 2025, at 10:05 a.m., the investigator observed unlicensed personnel (ULP)-D complete incontinence cares for R1. The investigator observed a thick scab on a wound measuring 1 cm x 1 cm on R1's left shin. ULP-D was unaware of how or when R1 got the leg wound. ULP-D asked R1 with the investigator present how or when she got the wound on the left shin and R1 stated she was unsure. On August 12, 2025, at 11:58 a.m., licensed practical nurse (LPN)-C stated ULP's had not reported any skin changes and the only wound LPN-C was aware of was a healed coccyx wound.	01620		

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01620	Continued From page 12 On August 12, 2025, at 11:58 a.m., clinical nurse supervisor (CNS)-B stated ULP's had not reported any skin changes and she was not aware of a left shin wound. On August 12, 2025, at 12:49 p.m., CNS-B and the investigator observed and measured R1's left shin wound. The wound had skin discoloration around the scab 3 cm in circumference and the scabbed area measured 1 cm x 1 cm. The licensee's Initial, and On-Going Nursing Assessment policy dated August 3, 2022, indicated a focused assessment would include an appraisal of a resident's status and situation such as falls, cognitive status, pain and skin contributing to the comprehensive assessment by the registered nurse (RN), support on-going data collection and deciding who needed to be informed of the information and when to inform. The RN must complete a progress note that an assessment was reviewed. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01620		