Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL201878103M
Compliance #: HL201878942C

Date Concluded: February 10, 2026

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

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name:
Katherine Barnhardt RN, Special Investigator

Finding: Substantiated, facility 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):
Licensed facility staff failed to implement adequate supervision for resident #2, when resident #2 displayed hypersexual behaviors and sought out resident #1. Facility licensed staff neglected resident #1 when licensed staff failed to review, adjust and implement interventions to protect resident #1 from resident #2.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment of Resident #1 and Resident #2. Facility licensed staff failed to assess, implement interventions, and provide adequate supervision of Resident #2 who had a known history of hypersexual behaviors toward Resident #1. Resident #2 entered resident #1's room when he was asleep and touched Resident #1's genital area without their consent on more than one occasion. Facility licensed staff neglected Resident #1 when licensed staff failed to implement new interventions to protect Resident #2.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, contract staff and unlicensed staff. The investigator contacted law enforcement and families. The investigation included review of the resident record(s), hospital records, pharmacy records, facility internal investigation, facility incident reports, personnel files, staff schedules, related facility policy and procedures. Also, the investigator observed unlicensed staff provide direct resident cares.

Resident #1 resided in an assisted living facility. Resident #1's diagnoses included dementia and adult failure to thrive. Resident #1's service plan included assistance with medication administration, bathing and I'm ok checks once per shift. Resident #1's assessment indicated he was hard of hearing, able to understand others and an assist of one in an emergency. Resident #1's individual abuse prevention plan indicated resident #1 was susceptible to abuse from another individual, including other vulnerable adults.

Resident #2 resided in an assisted living facility. Resident #2's diagnoses included stroke and chronic pain. Resident #2's service plan included assistance with I'm ok checks once per shift, bathing, meal escorts and behavior management. Resident #2's medical record indicated Resident #2 displayed hypersexual behaviors towards others, exposed himself to other residents, and masturbated in areas visible by other residents, staff and visitors. Resident #2's assessment indicated cognitive impairment, direct supervision required, poor decision-making skills, inappropriate sexual behavior towards others, and staff assistance for ambulation.

Review of facility records indicated an incident occurred where Resident #2 entered Resident #1's room while he slept and touched Resident #1's genital area. Resident #1 reported he was fearful of Resident #2 and did not feel safe. Following the first incident, Resident #2 was moved to another floor of the facility.

Documentation reviewed indicated Resident #2 continued to seek out Resident #1 and staff observed Resident #2 attempt to enter Resident #1's room multiple times following the incident and following the move of Resident #2 to another area of the facility.

A second incident occurred where staff found Resident #2 in Resident #1's room. Resident #1 reported that Resident #2 entered the apartment uninvited and Resident #1 awoke to Resident #2 touching his genital area.

Staff interviewed indicated that Resident #2 continued to make attempts to enter Resident #1's room despite being moved to another floor of the facility. Staff reported that the day the second incident occurred, Resident #2 made multiple attempts to enter Resident #1's room throughout the day and was redirected away from the door.

During an interview, unlicensed staff stated resident #2 exposed himself and masturbated in areas visible to co-residents, staff and visitors. Unlicensed staff stated resident #2 would sit facing the open apartment door when he displayed hypersexual behaviors, and staff would

close resident #2's door. Unlicensed staff stated facility staff had observed resident #2 trying to enter resident #1's room the day the second incident occurred.

During an interview, unlicensed staff stated resident #1 had two-hour safety checks and resident #2 was hourly safety checks. Unlicensed staff stated safety check times were adjusted after the second incident occurred. Unlicensed staff stated Resident #1 was also relocated to a new room on the opposite side of the facility due to Resident #2's persistence.

During an interview, licensed staff stated Resident #1 would forget to lock his door and facility staff would redirect Resident #2 away from Resident #1's door. Licensed staff stated Resident #1 verbalized Resident #2 had entered his apartment uninvited and Resident #1 appeared upset. Licensed staff stated after the second incident Resident #2's safety checks increased to hourly and "a little bit after" Resident #1's safety checks were increased to hourly.

During an interview, Resident #1 stated he took medication for sleeping every night and he woke up on his couch when Resident #2 undid his pants. Resident #1 stated it might have happened twice before however could not fully remember because he was sleeping, and it happened "once for sure" before. Resident #1 stated he moved rooms after the second incident because both incidents occurred in his previous room and he "just wants to forget about it".

During an interview, Resident #2 stated "my old neighbor" when the investigator asked if Resident #2 recalled being in Resident #1's room. Resident #2 denied being in Resident #1's room.

During an interview, a family member stated she spoke with Resident #1 often and tried to visit once a week. A family member stated Resident #1 phoned family after the second incident occurred and told family "Get me out of here". The family member indicated Resident #1 was in a "shear panic" and "100 percent fearful". The family member stated after the second incident, family was told the facility held a staff meeting to address the incidents.

In conclusion, the Minnesota Department of Health determined sexual abuse of resident #1 and neglect of resident #2 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.

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.

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: Not Applicable

Action taken by facility:
Facility licensed staff relocated resident #1 to a new room and increased resident #2’s safety checks.

Action taken by the Minnesota Department of Health:

The responsible party will be notified of their right to appeal the maltreatment finding.

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
Crow Wing County Attorney
Brainerd City Attorney
Brainerd Police Department
Crow Wing County Adult Protective Services

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 12/03/2025

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: #HL201878103M/#HL201878942C On December 3, 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 44 residents receiving services under the provider's Assisted Living license. The following correction order is issued for #HL201878103M/#HL201878942C, 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: Based on observations, interviews, and document review, the facility failed to ensure two of two residents reviewed (R1, R2) were free from maltreatment. Findings include: On December 3, 2025, the Minnesota Department of Health (MDH) issued a determination that neglect occurred, and that the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	02360		