Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL296479142M
Compliance #: HL296472980C

Date Concluded: April 17, 2026

Name, Address, and County of Licensee Investigated:
The Waters of Edina
6300 Colonial Way
Edina, MN 55436
Hennepin County

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

Evaluator's Name: Maerin Renee, 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 alleged perpetrator (AP) physically abused the resident via the use of physical restraint. The AP wheeled the resident into the community room against her wishes and positioned the resident's chair at a table, locking both sides of the chair. The resident could not unlock the brakes without staff assistance and was restrained in place.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was not substantiated. The AP's actions did not result in injury or harm to the resident and did not meet the statutory definition of abuse.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted family. The investigation included review of the resident record, death record, the facility internal investigation, facility incident

reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed resident cares provided by staff.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia. The resident's services included assistance with activities of daily living, meals, housekeeping, and medication management. The resident's assessment indicated she required maximum assistance with activities of daily living and was oriented to self only.

The facility internal investigation indicated a witness reported she had asked the resident if she wanted to be wheeled to the sitting area by other residents and the television. The resident said, "No." Later, as the witness prepared to leave, she saw the AP try to wheel the resident to the sitting area. The witness said it was clear the resident did not want to be pushed to the sitting area. The AP instructed the resident several times to put her feet up, while the resident's feet/legs were pinned backwards under the chair. The AP wheeled the resident to a table and locked the wheelchair in place.

Leadership reviewed surveillance video of the incident. The video showed the AP assisting the resident, who was sitting in a Broda chair (a large, customized wheelchair), into the community living room. The resident planted her feet on the floor, and the AP continued to push the Broda chair forward. The AP positioned the Broda chair at a table and then locked both sides of the chair. The resident was unable to independently unlock the breaks.

During an interview, the AP said she brought the resident into the community room. The resident was "planting her feet," and the AP asked the resident to pick up her feet. The AP explained she brought the resident into the community room because the AP was afraid the resident might fall. The AP said she positioned the resident's wheelchair against a table and locked the brakes so she would not move. Leadership asked if the AP understood positioning a resident against a table and locking the wheelchair brakes constituted restraint. The AP said she was aware but also expressed concern about the resident falling out of the chair. Leadership asked why the AP believed the resident was going to fall, as video footage showed no evidence of the resident attempting to stand or exit the wheelchair. The AP said the resident "kept moving" and the AP was attempting to stop her from moving.

The AP's training record indicated she completed training in preventing, recognizing, and reporting abuse. A knowledge quiz indicated the AP understood that staff use of restraint to keep a resident immobile or to make their job easier was reportable to the state.

After the investigation, the AP's employment at the facility was terminated.

Camera footage was not available for the investigator to review.

When interviewed, an administrator said a witness reported the AP pushed the resident in her wheelchair while the resident planted her feet. The administrator reviewed video footage and

saw the resident self-propelling in her wheelchair with her feet, wandering in her own way. The resident did not look distressed. The AP appeared in frame and tried to propel the wheelchair forward while the resident tried to stop the movement with her feet. The resident nonverbally indicated she did not want to move. The AP wheeled the resident against a table and locked both sides of the wheelchair. Initially the resident tried to move away from the table but then settled in and watched television. The administrator did not watch the entire video, so she did not know how long the resident sat at the table.

When interviewed, a supervisor said the resident was chair-bound and required full assistance with activities of daily living. In the video, the supervisor saw the AP pulling the resident back in her wheelchair and pushing her forward with her legs underneath the chair. The supervisor did not see the rest of the video. According to the supervisor, the AP said she did not know locking the resident's wheelchair in place at the table constituted physical restraint.

When interviewed, the AP said she cared for the resident and was concerned she was going to fall out of her wheelchair. Although the resident physically protested by planting her feet on the floor, the AP wheeled her into the community and placed her at a table. The AP locked the wheelchair to keep the resident in place. The AP said she was not aware wheeling the resident to a table and locking the wheelchair in place constituted a restraint.

In conclusion, the Minnesota Department of Health determined abuse 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.

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: No, deceased.
Family/Responsible Party interviewed: No, chose to not interview.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility completed an internal investigation of the incident. The AP is no longer employed by the facility.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29647	A. BUILDING: _____ B. WING _____	C 02/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WATERS OF EDINA	6300 COLONIAL WAY EDINA, MN 55436

(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 On February 10, 2026, the Minnesota Department of Health initiated an investigation of complaint #HL296472980C/#HL296479142M. No correction orders are issued.	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.	