Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL302352580M
Compliance #: HL302359300C

Date Concluded: July 27, 2026

Name, Address, and County of Licensee Investigated:
Brooke Manor INC
4878 Highway 31
Brookston, MN, 55711
Saint Louis 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 alleged perpetrator (AP) abused resident #1 when the AP hit resident #1. Resident #1 had a black eye and bruise on her forehead. The AP also abused resident #2 when the AP grabbed resident #2's wrist and twisted it in a forceful manner while resident #2 played cards.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was not substantiated. During the timeframe in question there was no documented evidence resident #1 had a black eye and/or bruise on her forehead. Resident #1 also had a behavior history of claiming current and past staff members had "hit" her. Resident #1 had a history of falls and bruised easily. Bruising was identified in fall incident reports and monitored. During the timeframe in question, a nurse assessed resident #2 and there were no observable signs of injury. Resident #2 had full range of motion with both wrists. The AP denied the allegations.

The investigator conducted interviews with facility staff members, including nursing staff, unlicensed staff, and the AP. The investigation included reviews of both resident records, facility incident reports, staff schedules, and related facility policy and procedures. The investigator contacted law enforcement, there was no data/report related to the allegations. Also, the investigator observed both resident #1 and resident #2 and staff interactions with both residents. In addition, the investigator observed the AP's interactions with resident #2 while resident #2 played cards.

Resident #1

Resident #1 resided in an assisted living facility. Resident #1's diagnoses included developmental disability, dementia, and paranoid psychosis. Resident #1's service plan included assistance with behavior management to include physical aggression, verbal aggression, socially inappropriateness, hallucinations, agitation/resistiveness, paranoia, and self-isolation. Resident #1's assessment indicated resident #1 made disparaging and/or negative remarks about staff and other residents. Resident #1 made untrue remarks about events. Staff were to question the validity of resident #1's remarks/reports, provide the resident direct feedback about giving false information, and staff were to document. Resident #1 had occasional hallucinations and delusional thoughts. Resident #1 had history of paranoid thoughts and hearing voices. Resident #1 had been heard saying "stop saying that to me" when resident #1 was alone in her room. Resident #1 had delusions that a deceased family member was present at the facility, resident #1 spoke to them, and the deceased family member told resident #1 things that were not true. Resident #1 had stated people were working in other rooms and seen people who were not present. Resident #1 accused staff of talking about her. Resident #1 was on medication for this. The assessment indicated resident #1 was unlikely to effectively communicate abuse due to cognitive impairment and compromised ability to verbalize thoughts and ideas. Resident #1 also had increased risk of falls, and a wheelchair was added for safety. Resident #1 was disoriented to place, time, and had a memory problem due to dementia. Resident #1 enjoyed coloring. Resident #1 was currently receiving hospice services.

Resident #1's record did not identify a black eye or bruise on her forehead during the timeframe/day in question.

Within the same month of the allegation, resident #1's progress notes, service delivery records, and behavior records indicated multiple occasions documented by multiple staff where resident #1 stated staff hit her in the head. Resident #1 leaned her head to one side. Resident #1 tilted her head so far to the left that food and medications fell out. There were occasions where the resident stated staff either "hit" or "smacked" her in the head. Resident #1 was assured by staff that no one was hitting her. Resident #1 said these comments when staff provided reminders for the resident to keep her head up, to straighten out her head, so her neck did not get sore. There was an occasion staff documented the resident made a statement against the AP that was "untrue" that the AP pushed resident #1's head onto her coloring table. Staff documented the AP was on the other side of the facility assisting a different resident at the time. There was

another occasion where resident #1 claimed the AP “hit” her, resident #1 was redirected by staff back to coloring.

Within the same month, resident #1’s incident reports indicated the resident had an occasion when she was moving around all day in her room, digging in drawers, in the closet, and looking at items on her bookcase. Resident #1 was also seen leaning over to pick “cake” (hallucination) off the floor. Resident #1’s side of her face was red from pressing against her knee while she was bending over from seated position in her wheelchair to reach the floor. Resident #1 had a start of a bruise on her left side of chin just below her mouth.

Resident #1’s fall incident reports indicated bruising was identified, assessed, and interventions were added. Progress notes indicated bruises were monitored.

Resident #1’s incident reports indicated resident #1 was at risk of bruising due to daily use of aspirin.

Resident #2

Resident #2 resided in an assisted living facility. Resident #2’s diagnoses included organic brain syndrome (impaired mental function), Alzheimer’s, and developmental disability. Resident #2’s service plan included activity assistance twice daily. Resident #2’s assessment indicated resident #2 was able to participate and follow rules for card games. Resident #2 would respond to her name and would wave. The assessment indicated It was unknown if resident #2 was oriented to place and time as resident #2 did not give any verbal responses. Resident #2 liked to play cards and played at the table.

During the timeframe/day in question, resident #2’s record did not identify any wrist injury. Within a few days of the alleged incident, resident #2’s progress notes indicated a physical assessment was completed, at that time resident #2 had no pain.

Within two weeks after the alleged incident, resident #2’s assessment indicated resident #2 had bruising on top of both her hands. Resident #2 was at risk for bruises related to a blood thinning aspect of one of her medications. The assessment indicated resident #2’s bruising especially to the top of her hands was common due to the bumping of her hands.

During an onsite observation, the AP was observed getting a deck of playing cards and handed them to resident #2 who was seated at the table. The AP’s tone of voice was not raised; the AP did not show physical aggression towards resident #2. Resident #2 did not cower, shrink away, or pull away when the AP was near. Resident #2 shuffled the deck of cards.

During an interview, nurse #1 stated she assessed resident #2. Resident #2 denied pain and there was no sign of injury to resident #2’s wrists or hands. Nurse #1 stated resident #2 had full range of motion with both wrists. Nurse #1 stated she had not seen the AP say anything or act in a way where resident #1 or resident #2 could have been fearful or scared. Nurse #1 also said

she had not seen any occasions where the AP grabbed resident #2 or any other resident's wrist and twisted it. During the timeframe in question, nurse #1 said she was not aware of resident #1 having a black/blue eye or bruise to her forehead.

During an interview, unlicensed personnel (ULP) #1 stated resident #1 had a behavior of making false accusations. ULP #1 stated he had not seen anyone say anything or act in a way where resident #1 or any other resident could have felt fearful or scared. ULP #1 said resident #1 had said the AP had hit and/or pinched her, however ULP #1 said this was not credible because the AP was not even present at the building when this was said. ULP #1 said he had not seen any injury or marks on resident #1's skin that could have been caused by somebody else. ULP #1 said there was an occasion when resident #1 pulled her bookshelf/dresser down onto herself and this hit her.

During an interview, ULP #2 stated she had not seen anyone say anything or act in a way where resident #1 or resident #2 could have felt fearful or scared. ULP #2 stated resident #1 made things up and was a "storyteller." Resident #1 has claimed staff have "hit" her. When resident #1 made claims, staff would ask if that was truthful statement or was it a story. ULP #2 provided examples of untruthful statements resident #1 would make. ULP #2 provided resident #1 assistance with toileting. Resident #1 would pull up her own incontinent brief and at the same time tell ULP #2 to stop "pushing" her, even though ULP #2 was not physically pushing her.

During an interview, the AP stated she did not physically hit resident #1. The AP stated she did not grab resident #2's wrist in a forceful manner and twist it. The AP stated resident #1 had a long-standing behavior history of claiming the AP and/or other staff members have hit her. Resident #1 sees things that are not there such as seeing kittens and puppies. The AP said she herself and others had looked into resident #1's prior claims and said they were unfounded. Resident #1 had claimed employees who were no longer employed there, who had not worked at the facility for 10 years, had come into the building and hurt her, which the AP said was false. The AP stated she did not say anything or act in a way where resident #1 or resident #2 could have felt fearful or scared.

During an interview, nurse #2 stated resident #1 had a cognitive disorder and her memory was poor. When resident #1 got mad, resident #1 made accusations against staff/others. Resident #1 claimed staff hit her, when they know resident #1 had a fall. Nurse #2 stated all incidents/injury/bruises were explanatory, and nurse #2 stated resident #1 bruised easily. When resident #1 made claims against staff, staff redirected. Nurse #2 provided an example of a claim resident #1 made. Resident #1 said staff pushed her down the stairs and she had to crawl back up the stairs. Nurse #2 stated they knew resident #1's claims were not true because there was no mark/injury on resident #1 and there would be no way physically resident #1 could have crawled up the stairs. Nurse #2 said resident #1 got frustrated and would say things that were not true. Nurse #1 stated there were also occasions, if resident #1 got mad she hit herself or pounded on herself with a closed fist, staff provide redirection. During the timeframe in question, resident #1 did not have a black/blue eye or bruise to her forehead. Nurse #2 stated

she had not seen anyone physically hit resident #1. Nurse #1 stated she had not seen anyone say anything or act in a way where resident #1 or resident #2 could have felt fearful or scared.

During an interview, resident #1's family member stated resident #1 had a history of stating someone has "hit" her. When the family member visited resident #1, resident #1 appeared happy. Resident #1 would get mad and during the visits would claim staff members were mad at her.

During an interview, resident #2's guardian stated he seen resident #2. He stated resident #2 was very much her usual self, there may have been a bruise on wrist, however he could not really tell. Resident #2 was using her hands/wrists just fine during the visit. Resident #2 did not say anything in regard to anyone grabbing her wrist and twisting it in a forceful manner. Resident #2's guardian stated there had been no further issues between staff members and resident #2 playing cards.

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: Yes, Resident #1 and Resident #2 attempted.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility assessed resident #1 and resident #2, assessed falls and/or incidents, assessed bruises, added interventions, and monitored.

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
	30235	A. BUILDING: _____ B. WING _____	C 07/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKE MANOR INC	4878 HIGHWAY 31 BROOKSTON, MN 55711

(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 July 1, 2026, the Minnesota Department of Health initiated an investigation of complaint #HL302359300C/#HL302352580M. No correction orders are issued.	0 000		