Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL304116863M
Compliance #: HL304111441C

Date Concluded: April 15, 2025

Name, Address, and County of Licensee Investigated:
Edgewood Brainer Senior Living
14890 Beaver Dam Road
Brainerd, MN 56401
Crow Wing County

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

Evaluator's Name: Willette Shafer, 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 the resident when the AP held the resident's apartment door closed so she was unable to leave her apartment.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was not substantiated. Although the AP held the door closed briefly to prevent the resident from exiting her apartment, the error was an isolated incident, and no harm occurred to the resident. The AP held the door to provide redirection of the resident's wandering so she would go back to bed. The facility provided abuse re-training to all staff who work at the facility.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family member. The investigation included review of the resident records, facility internal investigation, facility incident reports, personnel files, staff schedules, and related facility policies and procedures

Also, the investigator toured the facility and observed facility staff members providing care to the residents.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia, paranoid psychosis, and impulsivity. The resident's service plan included assistance with behavioral redirection, escorts, and safety checks. The resident's assessment indicated the resident was disoriented and needed redirection.

The internal investigation indicated unlicensed personnel (ULP)-1 heard the AP held the resident's apartment door shut to prevent the resident from exiting the room. ULP-2 observed the AP hold the door shut and told the AP holding a door shut was inappropriate. The AP admitted she held the resident's door shut to redirect the resident back to bed. The AP never witnessed a staff member hold a resident's door closed but said she was told by an unknown person she could. The internal investigation indicated five ULP were interviewed during the internal investigation. ULP-3 said she observed ULP-1 hold a door shut so a different resident was unable to exit their apartment. ULP-1 denied she ever held a door closed to prevent a resident from exiting their apartment and denied she ever witnessed someone hold an apartment door shut. The facility provided re-education to all staff who worked at the facility.

A nursing assessment completed after the incident indicated no change in the resident's mental or physical health.

During an interview, the AP said she held the resident's apartment door closed for 10 seconds to prevent the resident from exiting during the night shift. She said she tried to prevent the resident from leaving her apartment so she would go back to bed. The AP said she entered the resident's apartment immediately after holding the door to ensure the resident was safe. She said she received training on vulnerable adult maltreatment before and after the incident. She said this was the only time she had held a resident's door closed and said she would never do it again.

During an interview, a member of management who was also a nurse, said ULP-2 reported she observed the AP hold the resident's door closed. The facility conducted an internal investigation, the resident was assessed for safety, and the resident's family member was notified. The facility mandated all staff members complete vulnerable adult maltreatment regardless of when they last received education. The AP was a newly hired ULP and was honest about the incident and her error. The facility had adequate staffing during the incident.

During an interview, ULP-2 said she observed the AP hold the resident's apartment door closed to prevent the resident from exiting her room. The AP held the door closed for 15 seconds. The AP wanted the resident to go back to bed and prevent her from wandering. She said she received vulnerable adult maltreatment training before and again after the incident.

During an interview, ULP-3 said she thought she observed ULP-1 hold a different resident's door closed but she never said anything to unlicensed personnel-1 during the incident. She said during this incident she was standing at the medication cart located across the dayroom. She reported this to management. This was the only time she witnessed this type of incident.

During an interview, ULP-1 said she assisted with training the AP. She said she never told the AP she could hold a resident's door closed to prevent them from exiting their room. She said the AP was a new staff member and this was her first healthcare job. She said all staff received re-education on maltreatment of vulnerable adults after the incident. She said she never held a resident's door closed to prevent them from exiting their apartment.

During an interview, ULP-4 said she had never witnessed a staff member hold a resident's door closed to prevent them from exiting. She said she received vulnerable adult maltreatment training before and after the incident.

A voice message from the resident's family member indicated he was informed of the incident after it happened and the resident's mental health was unchanged due to the incident. He had no further information to add.

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, due to cognitive deficit.
Family/Responsible Party interviewed: No, family member left voicemail. No further information to add.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility completed an internal investigation, assessed the resident, and re-educated all staff members.

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
	30411	A. BUILDING: _____ B. WING _____	C 04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD BRAINERD SENIOR LIVING	14890 BEAVER DAM ROAD 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: HL304111441C/HL304116863M On April 8, 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 93 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for HL304111441C/HL304116863M, tag identification 2350.	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.	
02350 SS=E	144G.91 Subd. 7 Courteous treatment Residents have the right to be treated with	02350		

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02350	Continued From page 1 courtesy and respect, and to have the resident's property treated with respect This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide residents with a dignified alternative means to summon assistance when the licensee removed call pendant lights due to cognitive abilities for 3 of 3 residents (R3, R4, R5) reviewed. The licensee's alternate option to call for assistance was the residents yell for help if they needed assistance. 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R3's diagnosis included vascular dementia. R3's care plan dated March 20, 2025, indicated R3 was unable to activate the emergency call system due to cognitive deficit. The careplan directed staff need to anticipate needs, and complete safety checks every 30 minutes. During an observation on April 8, 2025, at 9:40 a.m., R3's call pendant light was not on person. Also, R3's apartment lacked an alternative means to summon for assistance. R4's diagnosis included Alzheimer's disease. R4's	02350		

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02350	Continued From page 2 care plan dated March 31, 2025, indicated R4 was unable to activate the emergency call system due to cognitive deficit. The careplan directed staff need to anticipate needs, and complete safety checks every 30 minutes. During an observation on April 8, 2025, at 9:43 a.m., R4's pendant light was not on person. Also, R4's apartment lacked an alternative means to summon for assistance. R5's diagnoses included vascular dementia. R5's care plan February 17, 2025, indicated R5 was unable to call for help but lacked documentation her pendant light had been removed. The care plan specified safety checks every 30 minutes but R5's service plan dated January 3, 2025, indicated safety checks three times per day. During an observation on April 8, 2025, at 9:45 a.m., R5's pendant light was not on person. Also, R5's apartment lacked an alternative means to summon for assistance. During an interview on April 8, 2025, at 9:41 a.m., unlicensed personnel (ULP)-H stated R3, R4, and R5's pendant lights were removed due to inability to use them. She said 80% of the residents who reside in the memory care area had their pendant lights removed. ULP-H said there was no alternate option to call for assistance; the resident would need to yell. During an interview on April 8, 2025, at 10:40 a.m., clinical services director (CSD)-B stated push pendants were removed for residents in memory care who were assessed as not capable to use appropriately. Residents who had their pendent lights removed would need to yell for help.	02350		

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02350	Continued From page 3 The licensee's Bill of Rights policy dated February 2022, indicated all staff members will be trained on the resident's Bill of Rights. TIME PERIOD FOR CORRECTION: Seven (7) days	02350		