

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL304119882M
Compliance #: HL304114682C

Date Concluded: April 20, 2026

Name, Address, and County of Licensee

Investigated:

Edgewood Brainerd Senior Living
14890 Beaver Dam Road
Brainerd, MN 56401
Crow Wing County

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

Evaluator's Name: Lena Gangestad, RN
Special Investigator

Finding: Inconclusive

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 she grabbed the resident forcefully by the left wrist and removed a glass of juice from her hand.

Investigative Findings and Conclusion: The Minnesota Department of Health determined abuse was inconclusive. The AP denied the allegations, and the resident could not be interviewed due to her cognitive impairment. While there was a witness and the AP may have treated the residents in a discourteous manner, there is insufficient evidence to demonstrate abuse occurred.

The investigator conducted interviews with facility staff members, including administrative staff, and unlicensed staff. The investigation included review of the resident's records, personnel files, staff schedules, policies, and procedures.

The resident resided in an assisted living secured memory care building. The resident's diagnoses include dementia. The resident's service plan included assistance with all activities of daily living.

A concern arose when the facility received a report the AP took the resident by the wrist forcefully.

During the internal investigation, the management team discovered an incident occurred a few days earlier in which the AP, an unlicensed caregiver, reportedly forcefully grabbed a resident's left wrist and removed a glass of juice from her hand during mealtime.

According to the facility's internal investigation, the AP stated she was handing a different resident a glass of juice when the resident took it. The AP stated another caregiver, unlicensed caregiver #1, began to yell at the AP to "just let her have it". The AP stated she found this frustrating to be yelled at and walked away to calm down.

During an email exchange, the AP declined an interview. The email indicated the AP was nowhere near the resident.

During an interview, the manager stated she received a report of the incident and spoke with unlicensed caregiver #1, who witnessed the event. The manager said she assessed the resident and observed a bruise on the resident's left wrist. The resident denied any pain. The manager noted that the resident had experienced a fall two weeks prior, and the bruise could have resulted from that incident. However, the resident had been assessed by a different nurse at the time of the fall, and no injuries were noted. The manager also stated the resident is known to wander and could have sustained the injury by contacting objects such as a door. As a result, it could not be confirmed the bruise was caused by the AP.

During an interview, unlicensed caregiver #1 stated she was in the dining room serving dinner when she observed the resident attempting to take a cup from another resident's table. She said she saw AP approaching quickly and began tugging on the resident's wrist. She stated she intervened and told the AP to stop, after which the AP yelled at her and walked away. She further stated he did not report the incident immediately because she did not recognize it as a serious issue but has since received education on timely reporting procedures.

In conclusion, the Minnesota Department of Health determined abuse was inconclusive.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.

"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or 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, unable to participate in an interview due to dementia.

Family/Responsible Party interviewed: No, attempted but did not reach

Alleged Perpetrator interviewed: Declined interview.

Action taken by facility: The facility initiated an internal investigation and terminated the AP. The facility also retrained all staff involved on timely reporting procedures.

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30411	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/04/2026
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NAME OF PROVIDER OR SUPPLIER EDGEWOOD BRAINERD SENIOR LIVIN	STREET ADDRESS, CITY, STATE, ZIP CODE 14890 BEAVER DAM ROAD BRAINERD, MN 56401
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(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	<p>Initial Comments</p> <p>On March 4, 2026, the Minnesota Department of Health initiated an investigation of complaints #HL304119882M/HL304114682C. No correction orders are issued.</p>	0 000		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____