Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL305603982M
Compliance #: HL305607728C

Date Concluded: September 16, 2025

Name, Address, and County of Licensee Investigated:
Brookdale Mankato
100 Teton Lane
Mankato, MN 56001
Blue Earth County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Lena Gangestad, 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) emotionally abused the resident when he called the resident "a liar and a druggie."

Investigative Findings and Conclusion: The Minnesota Department of Health determined abuse was not substantiated. AP delivered a medication cup to a resident and left it in the room when asked to check for an additional med. Upon return, the resident claimed the oxycodone was missing; the AP insisted it was included and called the resident a liar. While disrespectful, this did not meet the definition of abuse.

The investigator conducted interviews with the resident and unlicensed staff. The investigation included review of the resident's records, internal investigation documentation, incident reports, personnel files, staff schedules, policies, and procedures.

The resident resided in an assisted living facility. The resident's diagnoses chronic pain and major depressive disorder. The resident's service plan included assist with medication administration.

The resident was prescribed oxycodone, one tablet four times daily, with the first dose scheduled for 12:00 PM. She is also prescribed Linzess (linaclotide) 145 micrograms (mcg) as needed for constipation.

According to the narcotic book, the AP signed out one tablet of oxycodone at 1:50 PM.

During an interview, the resident stated the AP arrived around 2:00 PM, later than expected, and brought a medication cup that did not contain her Linzess. The AP left the room to check on the missing medication and returned stating it was not listed. When the resident asked about her oxycodone, the AP claimed it was already in the cup. The resident asked him to identify it in the cup, which he was unable to do. He insisted it had been included and accused the resident of taking it while he was out of the room. During the exchange, the AP became upset and allegedly stated, "You know, druggies do that. They lie about not being given medication to get more," and called the resident a liar.

During an interview, the AP confirmed he was agency staff, and this was his first and only shift at the facility. He received a 30-minute orientation. He reported signing out the oxycodone, placing all scheduled medications in the cup, and delivering it to the resident. She requested an additional medication, and he left the room to verify it. Before leaving, she asked about the oxycodone, and he told her it was in the cup. Upon returning, the resident claimed the oxycodone was missing. The AP acknowledged that leaving the medication cup unattended was a mistake. He admitted calling the resident a liar during their heated exchange and stated that his response was unprofessional.

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:
(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.

Vulnerable Adult interviewed: Yes.
Family/Responsible Party interviewed: Not Applicable.
Alleged Perpetrator interviewed: Yes.

Action taken by facility: The facility contacted the agency, and the AP was not allowed to return. He was also terminated from the agency.

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
	30560	A. BUILDING: _____ B. WING _____	C 07/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE MANKATO	100 TETON LANE MANKATO, MN 56001

(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 21, 2025, the Minnesota Department of Health initiated an investigation of complaints #HL305603982M/HL305607728C. No correction order is issued.	0 000		