Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL310681040M
Compliance #: HL310685060C

Date Concluded: April 22, 2026

Name, Address, and County of Licensee Investigated:
Marywood
915 Kenwood Avenue
Duluth, MN 55811
St. Lois County

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

Evaluator's Name:
Jana Wegener, 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 physically restrained the resident into her wheelchair using a transfer belt.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was not substantiated. Although the AP restrained the resident to her wheelchair with a transfer belt, the error was an isolated incident, and no harm occurred to the resident. The resident was observed on facility video surveillance restrained to her wheelchair with the transfer belt for about one hour. During that time the resident had no signs or symptoms of distress observed. When staff noticed the resident was restrained, they removed the transfer belt and reported the incident. When interviewed the AP admitted restraining the resident to her wheelchair and denied any malicious intent but rather intended to keep the resident safe. All staff were re-educated on use of restraints.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family. The investigation included review of the resident record(s), facility internal investigation, personnel files, staff schedules, facility video surveillance, and related facility policy and procedures. Also, the investigator observed residents and staff at the facility.

The resident resided in an assisted living facility memory care unit with diagnoses including dementia, Alzheimer's disease late onset, and anxiety disorder. The resident's assessment and plan of care indicated the resident was severely cognitively impaired. The assessment and plan of care indicated the resident was at risk of falls and required assistance from staff with transfers using a transfer belt.

The facility investigation documentation indicated the AP applied a transfer belt to restrain the resident to her wheelchair. The investigation indicated when staff became aware the resident was restrained, the transfer belt was immediately removed, and the incident was reported to leadership. The investigation indicated when the AP was interviewed by facility leadership, the AP stated she was trying to keep the resident safe and prevent her from falling. The AP explained the resident had multiple self-transfers that morning and non-pharma logical interventions tried were ineffective. The investigation indicated the resident sustained no injuries and had no emotional distress noted as a result of the incident.

A review of facility video surveillance from the common area during the time of the incident showed the resident walking out of her room without assistance then the AP rushed to prevent the resident from falling while another staff went to get the resident her wheelchair. The AP was observed assisting the resident into her wheelchair then secured the transfer belt around the wheelchair and the resident's waist. The resident was observed propelling herself around the unit until staff noticed the transfer belt and removed it approximately one hour later. The resident appeared calm, with no signs of agitation or distress while the transfer belt was in place.

When interviewed, facility leadership stated they had no concerns with the AP's conduct prior to the incident and indicated the incident was isolated. Facility leadership stated the AP had no malicious intent and was trying to keep the resident safe.

When interviewed, several unlicensed staff stated they had no concerns with the AP's conduct prior to the incident. Staff stated they received re-education on restraints after the incident.

When interviewed, the AP admitted applying the transfer belt to keep the resident in her wheelchair but indicated the resident was able to mobilize and she did not think it was a restraint. The AP stated she had never used a transfer belt to restrain the resident before and indicated the transfer belt was around the back of the chair and she thought it was there to help keep the resident in her wheelchair. The AP denied any intent to cause harm or distress to the resident and stated she was trying to keep the resident safe.

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:
(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.

Vulnerable Adult interviewed: Yes.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
Facility staff removed the restraint, reported the incident and the AP was suspended pending investigation into the incident. All staff were re-educated on what constitutes a restraint, the prohibited use of restraints, and the resident’s right to be free from restraints.

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
	31068	A. BUILDING: _____ B. WING _____	C 02/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARYWOOD	915 KENWOOD AVENUE DULUTH, MN 55811

(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 17, 2026, the Minnesota Department of Health initiated an investigation of complaint #HL310681040M/#HL310685060C. No correction orders are issued.	0 000		