Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL312147162M
Compliance #: HL312146686C

Date Concluded: March 18, 2026

Name, Address, and County of Licensee Investigated:
Nagel Assisted Living
232 South Elm Street
Waconia, MN 55387
Carver County

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

Evaluator's Name: Julie Serbus, 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), an unlicensed staff, abused the resident when the AP verbally made an inappropriate statement prior to physically restraining the resident's wrists/lower arms during personal cares.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was not substantiated. Although the AP's actions were inappropriate, the actions did not meet the definition of abuse. An incident occurred with a resident's brief while providing incontinent care for the resident. The AP did make a verbal statement and briefly restricted the resident's hands protecting another unlicensed staff from harm for the resident's care to be completed safely. The resident received the care to prevent skin breakdown and provide dignity. No medical attention was necessary, and the resident returned to her baseline.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted a family member. The investigation included a review of the resident record, facility internal investigation, personnel file, staff schedules, related facility policy and procedures. Also, the investigator observed facility residents and staff member interactions during an onsite visit.

The resident resided in an assisted living memory care unit. The residents' diagnoses included dementia with behaviors and multiple mental health disorders. The resident's service plan included physical assistance with dressing, toileting, and medication administration. The resident's assessment indicated the resident needed assistance with all activities of daily living. The resident resided in the facility for less than a 5-month period and was non-compliant with personal cares daily (requiring additional team member(s) for safety).

A concern arose one evening when staff were required to physically assist the resident to wash up and apply a clean brief and clothing related to an incontinent bowel movement. Two unlicensed staff were located on the unit and notified staff from another unit to assist related to aggressive behaviors of the resident. A total of four staff (AP along with three other unlicensed staff) responded to provide the care. The resident had a history of becoming physically aggressive towards staff including pulling of hair, pinching, punching, and kicking.

The facility internal investigation report indicated there were conflicting narratives between the AP and other witnesses present. The document indicated an incident had occurred and possibly caused emotional distress and physical pain with no injuries. The resident quickly returned to baseline when the AP released the resident's wrists/arms and the incontinent care was completed by staff.

During an interview, unlicensed staff #1 stated it was normal for three to four staff to complete cares due to the resident's aggressions towards staff. Unlicensed staff #1 stated AP had made an inappropriate comment to the resident and then grabbed her wrists when the resident became aggressive. Unlicensed staff #1 stated she was caught off guard by the AP's actions.

During an interview, an unlicensed staff #2 stated there were four unlicensed staff in the room. Unlicensed staff #2 was in the process of starting cares when the resident punched her in the chest hard and pulled her hair. Unlicensed staff #2 stated the resident moved around a lot when trying to provide cares. Unlicensed staff #2 stated it was at that time when the AP made an inappropriate comment towards the resident and then grabbed the resident's arms to hold them down as the resident was pulling unlicensed staff #2's hair. The AP continued to hold down the resident's arms above the wrists so cares could be completed. Unlicensed staff #2 stated that was the first time she had heard the AP swear at a resident and unlicensed staff #2 felt it was less than a minute when she asked AP to let go of the resident wrists which the AP did and left the room. Unlicensed staff #2 stated when she came out of the room AP no longer working and was not sure if she asked to leave her shift early or if she was sent home.

During an interview, unlicensed staff #3 stated she thought the AP restrained the resident using a bearhug hold which would hold down the resident's arms so the resident could not continue to strike out at staff. Unlicensed staff #3 was not certain but stated AP would have had to have been standing behind the resident and would have had her arms wrapped around her chest to keep her arms close to her body as the resident was standing up while staff were trying to clean her up and get a clean brief and clothes on her. I did not hear exactly what AP had said to the resident. The resident calmed down after cares were completed. Unlicensed staff #3 stated she reported the incident to the lead staff immediately after leaving the room.

During an interview, a licensed nurse stated the resident had multiple interventions in place to include redirect, reapproach, and nursing continued to come up with new interventions. It was not unusual for two to three staff present to assist with care and provide safety for both staff and the resident. The AP was sent home just before the licensed nurse arrived at work. Licensed nurse stated she had never witnessed the AP having any bad interactions with the resident or any other resident's prior and was surprised to hear what had happened.

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.

Vulnerable Adult interviewed: No.
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: No, The AP declined to complete an interview

Action taken by facility:
The facility suspended the AP and completed an investigation. The AP is no longer employed at the facility.

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
	31214	A. BUILDING: _____ B. WING _____	C 01/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NAGEL ASSISTED LIVING	232 ELM STREET SOUTH WACONIA, MN 55387

(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 January 7, 2026, the Minnesota Department of Health initiated an investigation of complaint #HL312146686C/#HL312147162M. No correction orders are issued.	0 000		