Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL314742924M
Compliance #: HL314741528C

Date Concluded: August 13, 2026

Name, Address, and County of Licensee Investigated:
The Waters of Mayowood
827 Mayowood Road Southwest
Rochester, MN, 55902
Olmsted County

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

Evaluator's Name: Kris Detsch, 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 they physically restrained her so another staff member could administer medication.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was not substantiated. The resident had aggressive, combative behavior which posed a risk to other residents, so multiple staff attempted to give her prescribed anti-psychotic medication. At one point during this process, the AP held the resident's arms/hands to prevent her from hitting an unlicensed personnel (ULP). Although the AP's behavior restrained the resident's movement, this event was brief, done in therapeutic conduct, and the resident suffered no harm.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident records, facility internal investigation, facility incident reports, personnel files, staff schedules, and

related facility policy and procedures. Also, the investigator toured the facility and observed staffing levels, documentation systems, and medication administration.

The resident resided in an assisted living memory care unit. The resident's diagnoses included Alzheimer disease, adjustment disorder (mood disorder), and kidney disease. The resident's service plan included assistance with dressing, grooming, toileting, medication administration, transfers, and walking. The resident's nursing assessment indicated she had severe memory impairment. The resident's behavior included hitting other residents, refusing care assistance, and wandering throughout the unit.

During an interview, a nurse manager said a ULP told her the AP held the resident's arms back while he attempted to give the resident medication. The manager said she told the ULP to report the incident to the director. The nurse manager said she had no other role in the investigation.

During an interview, the director said she investigated the incident. Multiple staff attempted to give the resident her medication; however, the resident began to hit and spit. The ULP told the director, the AP held the resident's arms back while he tried to give the resident anti-psychotic medication. The director said the ULP told her he was "taken back" when he saw the AP hold the resident's arms, so he stopped trying to give the medication and left the resident's apartment. The director said it was unclear who (which staff member) gave the resident the medication because staff gave conflicting accounts. The director said the ULP was responsible for the complete medication administration process, not the AP. The facility had not trained the AP to give medication, and it was unclear how she became involved in the medication administration process. The director said the facility did not allow staff to "restrain" the residents in any way and provided re-education to the other staff members.

The facility's internal investigation included a timeline description from video footage. Although the incident occurred within the resident's apartment, outside of the camera view, the camera footage showed when the AP and the ULP entered and exited the resident's apartment. This encounter lasted less than two minutes. Additionally, about fifteen minutes prior to this incident, a nurse also attempted to give the resident the medication, but was unsuccessful.

The resident's medication administration record lacked indication any staff member gave the resident antipsychotic medication at the time of the incident.

Progress notes the day of the incident described the resident as "very" agitated. Her behavior included wandering, yelling, hitting and spitting.

Nurse practitioner (NP) documentation indicated she was at the facility on the day of the incident, and she described the resident as being "very aggressive and irritated" so she increased the dosage of the resident's antipsychotic mediation. The NP assessed the resident the following day and determined the resident had a "drastic increase" in her aggressive

behaviors including hitting, spitting, and punching staff and other residents. The NP added additional medications to manage these behaviors.

The ULP did not respond to request for interview.

During an interview, the AP said the ULP asked for help because he needed to give the resident medication. The AP said she held the resident's hands back because she was hitting the ULP. The AP said this lasted no longer than thirty seconds. The AP said she only did this because the resident was hitting the ULP and he asked her to help him.

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;
(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; and
(4) use of any aversive or deprivation procedures for persons with developmental disabilities or related conditions not authorized under section 245.825.
(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.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility provided re-education to staff.

Action taken by the Minnesota Department of Health:
No further action taken.

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
	31474	A. BUILDING: _____ B. WING _____	C 08/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WATERS ON MAYOWOOD	827 MAYOWOOD ROAD SW ROCHESTER, MN 55902

(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 August, 5, 2026, the Minnesota Department of Health initiated an investigation of complaint #HL314741528C/#HL314742924M. No correction orders are issued.	0 000		