Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL324524782M
Compliance #: HL324529928C

Date Concluded: October 17, 2025

Name, Address, and County of Licensee Investigated:
The Meadows
1761 Eagle View Circle
Albert Lea, MN 56007
Freeborn County

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

Evaluator's Name: Brandon Martfeld, RN, BSN, 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 the AP became hostile, impatient, derogatory, and yelled at the resident during a shower.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined emotional abuse was not substantiated. There was not a preponderance of evidence to support the AP's actions rose to the level to of threatening, harassing or disparaging with emotional distress.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident records, video footage, facility internal investigation, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed staff and resident interactions.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia and anxiety. The resident's service plan included assistance with dressing and bathing. The resident's assessment indicated the resident was cognitively impaired and had behaviors that included being resistive to cares, verbally aggressive, physically aggressive, inappropriate sexual behavior, angry outburst, and cursing/swearing. The resident's assessment indicated staff were to remind the resident that the behaviors were not appropriate. The resident's assessment indicated the resident required one staff for assistance with bathing and dressing.

In a series of 10 videos ranging from 15 seconds to two minutes and 15 seconds, a staff member and the AP could be seen in the resident's room. A staff member removed the resident's sheets and blankets and made the resident's bed while the AP completed the resident's shower. At times during the videos the bathroom door was slightly open and at times the bathroom door was completely closed due to the staff member and AP entering and exiting the bathroom. The AP and resident could be heard on the videos as the AP assists the resident with a shower. The AP told the resident to close her eyes and tilt her head back so that the shampoo could be rinsed out. The resident made numerus inaudible words/noise, and the AP could be heard saying no to the resident multiple times including a statement the resident threw her washcloth. After the resident's shower, the AP came out of the bathroom and told the staff member, "she pinched my boob" and "spit in my face" while the AP wiped her face with a towel. The end of the videos showed the staff member and the AP assisting the resident with getting dressed, brushing her hair, and escorting the resident out of the room. The videos showed the resident did not appear to be distraught, fearful or in emotional distress.

During an interview, unlicensed staff member stated the AP started giving the resident a shower. The resident did not like water on her and would say the water was usually too cold or too hot. During the shower, the resident splashed water and pinched the AP. After the shower, the resident was assisted with getting dressed and brought out to a common area.

During an interview, the AP stated during the shower the bathroom door was closed for privacy. During the shower the resident was kicking at her and the resident was told no, do not do that. The AP also stated the resident spit in her face. During the shower, the resident was also given a washcloth to cover her eyes so that shampoo would not get into her eyes, but the resident had thrown the washcloth. The AP stated after the shower, the resident was dressed in her pajamas and assisted out to the living room.

During an interview, facility leadership stated the resident had cognitive decline due to dementia and would often strike out, hit, or pinch staff. The resident did not like showers because she did not like the water going over her eyes. After the incident staff was educated regarding working with residents with dementia and audits were completed during resident cares.

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: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility suspended the AP pending an investigation, provided education to staff regarding working with resident’s with dementia and completed audits for the resident cares. The AP is no longer employed by 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
	32452	A. BUILDING: _____ B. WING _____	C 09/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MEADOWS	1761 EAGLE VIEW CIRCLE ALBERT LEA, MN 56007

(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 September 8, 2025, the Minnesota Department of Health initiated an investigation of complaint HL324524782M/HL324529928C. No correction orders are issued.	0 000		