

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL336511080M
Compliance #: HL336515004C

Date Concluded: April 29, 2026

Name, Address, and County of Licensee

Investigated:

Bay Harbor Senior Living of La Crescent
1384 County Road 25
La Crescent, MN 55947
Houston County

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

Evaluator's Name: Michele Larson, 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):

An alleged perpetrator (AP) abused the resident when they forcefully pushed the resident's specialized wheelchair (a self-propelled pedal Broda Chair) while the resident sat in the chair, causing the resident to fall on the floor.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined abuse was not substantiated. It was unable to be determined if abuse occurred. Although the resident fell, the Broda Chair use was not indicated on the service plan, the AP denied intentionally harming the resident and was not trained on the use of the Broda Chair. The resident was assessed and monitored for injury and returned to their baseline health status.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family member, the resident's hospice company, the medical equipment company who supplied the resident's

Broda chair, and the company who wrote the instruction manual. The investigation included review of the resident record, hospice record, hospital record, facility internal investigation documentation, facility incident reports, personnel files, staff schedules, law enforcement report, facility video footage, and related facility policy and procedures. Also, the investigator observed resident and staff interactions during the onsite investigation.

The resident resided in an assisted living memory care unit. The resident's diagnoses included advanced Alzheimer's disease. The resident's service plan indicated she required staff assistance from one staff member with toileting. The resident's assessment indicated she was oriented to self only but was able to make her needs known. The resident also received Hospice services from an outside agency.

The resident's hospice record indicated a hospice nurse ordered a self-propelled Broda chair for the resident due to the resident's recent falls, however the resident's service plan was not updated to indicate the use of the chair.

An incident report indicated the resident sustained a witnessed fall in her bathroom after the resident planted her feet on the lip of the bathroom doorway, causing her to fall out of her wheelchair. A hospice nurse assessed the resident later that evening. The hospice nurse observed a large hematoma (bruise) on the resident's left forehead along with bruising on both hands. Staff were instructed to perform frequent overnight checks to monitor the resident's condition and injuries. An x-ray was later obtained to assess for potential wrist fracture. The x-ray was negative.

The facility investigated and reported the incident. Police opened an investigation and closed with no charges filed. Camera footage reviewed showed the AP wheeling the resident to the bathroom. The resident's feet dragged across the floor, the resident leaned and slumped to her left side. The resident's Broda chair was not reclined, and the resident had no footrests to support her feet. The AP stopped at the bathroom entrance and appeared to speak to the resident then pulled the resident's Broda chair backwards and forcefully pushed it over the bathroom entryway, causing the resident to fall out of her Broda chair onto the bathroom floor. The resident could not be seen in camera view after falling out of the chair. The AP was seen exiting the resident's apartment and returning moments later with another staff member who helped to assist the resident off the floor.

Review of the resident's medical record indicated the use of the new Broda chair was not documented on the resident's service plan and was not included in the resident's assessment. The medical record included no documentation on direction for staff on how to utilize or operate the resident's Broda chair.

The AP's employment file did not include training on the use and operation of a Broda chair.

When interviewed, an unlicensed staff member stated they did not recall seeing footrests on the resident's Broda chair and stated the resident had issues with keeping her feet lifted while staff pushed the resident in her Broda chair. The staff member stated the resident's feet would get caught, stating that was what probably caused the incident. The staff member stated he received Broda chair training from another unlicensed staff member when he started working at the facility but did not receive any training from facility leadership on Broda chair use or operation.

When interviewed, the AP stated at the time of the incident she backed up the Broda chair to get over a bump at the bathroom entrance. The AP stated it was difficult at times to get the Broda chair wheels over the bump and Broda chairs were difficult to steer and push. The AP stated she never received Broda chair training from the facility, and it was difficult to perform her job without proper training. The AP stated she was "scared and frightened" at the time of the incident but immediately reported the fall and got another staff member to assist and check on the resident. The AP stated she was in shock and cried after the incident, and she never intended to harm the resident and felt deeply sorry for the situation.

When interviewed, hospice agency staff stated back rests should be tilted whenever they were pushed in their Broda chairs to avoid the resident's feet from getting caught. Hospice staff confirmed the resident's Broda chair came with footrests when the Broda chair was delivered to the resident. Hospice staff stated their agency offered to provide Broda chair training to facility staff, but facility leadership declined their offer, stating they preferred to train their own staff.

Facility nursing staff indicated the AP was terminated as a result of the incident. All staff were retrained and a new chair was ordered for the resident.

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.

(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 due to cognitive impairment.

Family/Responsible Party interviewed: Yes.

Alleged Perpetrator interviewed: Yes.

Action taken by facility:

Facility leadership investigated, reported the incident and retrained staff.

Action taken by the Minnesota Department of Health:

The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

<https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html>

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

You may also call 651-201-4200 to receive a copy via mail or email.

cc:

The Office of Ombudsman for Long Term Care

The Office of Ombudsman for Mental Health and Developmental Disabilities

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33651	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/27/2026
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NAME OF PROVIDER OR SUPPLIER BAY HARBOR SENIOR LIVING OF LA CRESCCE	STREET ADDRESS, CITY, STATE, ZIP CODE 1384 COUNTY ROAD 25 LA CRESCENT, MN 55947
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(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
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0 000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>ASSISTED LIVING PROVIDER CORRECTION ORDER</p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation.</p> <p>Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance.</p> <p>INITIAL COMMENTS:</p> <p>#HL336515004C/#HL336511080M</p> <p>On February 27, 2026, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 71 residents receiving services under the provider's Assisted Living with Dementia Care license.</p> <p>The following correction orders are issued for #HL336515004C/#HL336511080M, tag identification 1640.</p>	0 000	<p>Assisted Living Provider 144G.</p> <p>Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction.</p> <p>PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p> <p>THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.</p>	
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Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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01640	Continued From page 1	01640		
01640 SS=D	<p>144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to</p> <p>(a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan.</p> <p>(b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities.</p> <p>(c) The facility must implement and provide all services required by the current service plan.</p> <p>(d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable.</p> <p>(e) Staff providing services must be informed of the current written service plan.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and document review the licensee failed to ensure the service plan was revised based on resident assessment to include all services required for one of one resident (R1) reviewed.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a</p>	01640		

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01640	<p>Continued From page 2</p> <p>limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).</p> <p>The findings include:</p> <p>R1's record was reviewed. R1 admitted to the facility on June 13, 2024. R1's diagnoses included but were not limited to late-onset Alzheimer's disease, history of falling, and visual hallucinations. R1 was admitted to hospice services on October 11, 2024.</p> <p>R1's comprehensive 90-day assessment dated November 26, 2025, completed by registered nurse (RN)- B, indicated R1 required daily physical assistance from one staff with grooming, toileting, denture care, meals, escorts, and physical assistance from two staff for transfers, ambulation, dressing, and bathing. R1 was oriented to self only, had difficulty communicating and using her call pendant, but was able to make her needs known. R1 was at high risk for falls. R1 used a manual wheelchair for mobility.</p> <p>R1's service plan dated December 15, 2025, indicated R1 required assistance with putting on and taking off her compression stockings, medication administration, weekly showers and vital signs, laundry, safety checks four times per day, and toileting assistance of one staff person. R1 was independent with ambulation and grooming. R1's service plan indicated she used a cane for mobility.</p> <p>R1's December 15, 2025 service plan was not updated to include the information from the November 26, 2025 assessment to indicate R1 required physical assistance of one staff for grooming, meals, denture care, escorts and</p>	01640		
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01640	<p>Continued From page 3</p> <p>assistance from two staff members for dressing, bathing, transfers, and ambulation or R1's use of manual wheelchair. R1's December 15, 2025 service plan continued to indicate R1 was independent with mobility.</p> <p>R1's hospice record dated January 21, 2026, at 6:50 a.m., indicated R1's hospice nurse ordered a Broda chair for R1 due to recent falls. R1's Broda chair was delivered on January 21, 2026, at 10:54 a.m.</p> <p>R1's record lacked evidence R1's service plan and assessment were updated to reflect R1's use of a Broda chair.</p> <p>On January 25, 2026, R1 sustained a fall after an unlicensed personnel (ULP)-I attempted to push R1's Broda chair into the bathroom and R1's feet were caught beneath her while ULP-I attempted to push the chair over the lip of the floor between the room and the bathroom. Video camera footage of the incident reviewed revealed R1 was not properly positioned in the Broda chair and the footrests were not applied to the chair.</p> <p>On February 27, 2026, the facility Registered Nurse (RN)-B confirmed R1 sustained a fall on January 25, 2026 and camera footage reviewed identified concerns with ULP-I's handling of R1 in the Broda chair. RN-B indicated she was the nurse responsible for resident assessments, education and training of staff. RN-B acknowledged R1's service plan was not updated to include the use of the Broda chair.</p> <p>On March 9, 2026 at 11:34 a.m. ULP-I was interviewed and stated she was not trained on how to use or operate R1's Broda chair.</p>	01640		
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01640	Continued From page 4 No further information was provided. Time Period for Correction: Twenty-One (21) Days.	01640		