Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL366361040M
Compliance #: HL366361081C

Date Concluded: June 13, 2025

Name, Address, and County of Licensee Investigated:
Cedar Creek Senior Living
19131 Taylor Street Northeast
East Bethel, MN 55011
Anoka County

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

Evaluator's Name: Lissa Lin, 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 she restrained the resident's arms during toileting cares.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was not substantiated. The AP followed the service plan which instructed two staff to assist with toileting cares. There was conflicting information on the AP's placement of her hands on the resident during toileting but no indication she placed the resident in a "head lock." The facility suspended the AP during their investigation. She was re-educated on conduct and safe transfers and returned to work. The resident was unharmed.

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 investigation included review of the resident records, the facility internal investigation,

facility incident reports, personnel files, staff schedules, and related facility policy and procedures. The facility was not able to produce camera footage for the investigator. The investigator observed the resident in the memory care common area.

The resident lived in an assisted living memory care unit. Her diagnoses included unspecified dementia, repeated falls and muscle weakness. The resident's service plan included assistance with toileting. She was resistive to cares and required two staff members to complete toileting, undergarment changes or peri-cares. If the resident remained resistive to cares, staff members were instructed to make sure she was safe, reapproach her later to attempt cares, and consider letting an alternative care giver assist her.

Review of facility incident records indicated one night the resident entered the memory care common area, pulled down her brief and urinated on a chair. A staff member approached the resident to clean her up and change her brief. The resident struck out at the staff member. A second staff member went behind the resident, placed her arms under the resident's armpits and locked her hands behind the resident's head to stop her from hitting the first staff member. The first staff member said she was okay. The second staff member was asked to step away from the resident and immediately suspended while an investigation was conducted. The nurse assessed the resident, who was unharmed. Camera footage was reviewed. The report did not identify staff members.

An investigation summary indicated camera footage showed the AP stood behind the resident and placed her arms under the resident's arms for less than 5 seconds, then released her arms. The resident's arms did not change from their normal resting position and the AP did not raise or place the resident's arms in a "hold" or clasp the resident's hands behind her head. Some internal investigation staff interviews indicated the AP "forcefully" held the resident's arms.

During an interview, the AP said after the resident urinated on the chair, she and other staff members went to help the resident to her feet to get cleaned up. The AP said she had one arm under the resident's arm and held her hand. The AP said later she was reported for putting the resident in a "head lock." The AP said she did not know what that a head lock was and looked it up. She said she did not put the resident in any hold and was upset that someone would say that about her. She said she was trained to hold the resident's hands and distract her if she hit out at staff during cares. She asked to see the camera footage from that night, but management declined. The AP said she was suspended for one day, re-educated, and returned to work.

During an interview, a nurse manager said the resident can strike out at staff and hit hard, which was why cares were done in pairs. Staff members could hold the resident up when changing her, so she would not fall. The nurse manager said holding a resident does not mean restraining her arms, but if she could move her arms and was safe that would be acceptable. The nurse manager said she was not employed at the facility at the time of the incident.

During an interview, the staff member who changed the resident's brief said she was looking down and cleaning the resident when the AP came up behind the resident and put her arms under the resident's armpits and pulled her shoulders back. The staff member said she did not see the resident's arms pulled over her head. The staff member could not say the AP's action was abuse. The resident was not harmed.

Another staff member who worked that night declined an interview.

During an interview, the resident's family member said he was not aware of any restraint issue. The facility was good about updating him with falls or other concerns.

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; Stop here if it is not a restraints issue or sexual abuse.
(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.

Vulnerable Adult interviewed: No, due to diagnoses.
Family/Responsible Party interviewed: No, not aware of incident.

Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The resident was assessed for harm. The AP was suspended pending an internal investigation. The AP and all other staff received re-education.

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
	36636	A. BUILDING: _____ B. WING _____	C 06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR CREEK SENIOR LIVING	19131 TAYLOR STREET EAST BETHEL, MN 55011

(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 June 4, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL366361081C/#HL366361040M. No correction orders are issued.	0 000		