Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL420279343M
Compliance #: HL420273522C

Date Concluded: May 20, 2026

Name, Address, and County of Licensee Investigated:
Eden Homes and Care Services
18741 Ivanhoe Street Northwest
Elk River, MN 55330
Sherburne County

Facility Type: Unlicensed Facility

Evaluator's Name: Holly German, RN
Special Investigator

Finding: Inconclusive

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 the AP engaged in a physical altercation with the resident.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was inconclusive. Both the AP and the resident reported a conflict occurred when the AP removed a space heater from the resident's room and the resident followed the AP to the facility living room. The AP stated the resident attempted to hit her and he fell out of his wheelchair. The resident stated the AP hit him and pushed him out of his wheelchair. There was a lack of corroborating evidence to support the AP or the resident's report of the incident. There was no visible signs of injury to the resident, no witness and no video footage available to review.

The investigator conducted interviews with facility staff members, including administrative staff and unlicensed staff. The investigator contacted law enforcement and attempted to contact the

case worker. The investigation included review of the resident records, facility incident reports, personnel files, staff schedules, law enforcement reports, related facility policy and procedures. Also, the investigator observed resident and staff interactions while on site.

The resident resided in an assisted living facility. The resident's diagnoses included paraplegia, type 1 diabetes, opioid abuse, and post-traumatic stress disorder. The resident's service plan included assistance with behavior management, safety checks, wound care, and transfers. The resident's assessment identified the resident as independent with wheelchair use and decision making. The resident had a history of threatening staff with a knife, throwing items, and recording staff on his cellphone while verbally abusing staff. The assessment indicated the resident required assistance with transfers out of bed.

A facility incident report indicated the resident had a fall from his wheelchair. The report indicated the AP removed a heater from the resident's room. When the resident attempted to get the heater back from the AP, he used his wheelchair to run over the AP and pushed the AP. The report indicated when the resident attempted to grab the heater, the resident fell from the chair to the floor due to the wheelchair only having one arm rest in place. The fall did not result in any injuries, but the dressing on the resident's chronic wound came off and wound drainage was noted on the floor. The report indicated law enforcement was called, and the resident refused medical evaluation by emergency medical services staff.

A law enforcement report indicated officers arrived at the facility and noted the resident on the floor in the facility living room. The officers assisted the resident back into his wheelchair. The report indicated an officer spoke to the AP who stated she removed a space heater from the resident's room, and the resident followed her to the facility living room. The AP stated when the resident attempted to remove the heater from the AP's hand and the resident fell out of his wheelchair to the floor due to the wheelchair armrests not being attached. The resident would not speak to the officer about his health and declined all offered medical attention. The report indicated a security camera was noted in the living room and the officer requested the footage. An officer spoke to the resident and the resident stated the AP had advised him he was not supposed to have a space heater in his room because it blew the electrical fuses. The resident stated he followed the AP out of his room and attempted to grab the heater from the AP, but the AP stuck her arm out and blocked him from taking it. The resident stated he and the AP "got to tussling," and the AP punched him and pushed him away. The resident stated the AP used both of her hands to push him out of his wheelchair and advised the officer to check the facility camera. The officer did not observe any injuries to the resident beyond the chronic wound on his buttocks. The resident stated if he continued to live at the facility, he was going to do something to the AP to go to jail. The officer witnessed the resident replacing the armrests on his wheelchair while speaking to the resident about the incident. The officers determined no crime was committed.

There was not a video to review of the incident.

During an interview, the AP stated the resident admitted to the facility after being evicted from his previous facility for hitting another resident. The AP stated she quickly learned the resident was not compliant with neither his psychiatric care, his behavioral support plan, nor his physical care needs. The AP stated the resident was the only resident in the facility. The AP stated the resident threatened to shoot the facility, brought knives into the facility, and refused cares to the point they had to call 911 for help. The AP stated the wound care company refused to continue services to the resident due to the knives he had. The AP stated the facility temperature was set at 72 degrees and the resident was told he could not have a portable heater in his room. The AP stated the resident required the use of an air mattress and bed that both were plugged in, in addition to other medical equipment that required charging. Therefore, the heater would trip the breakers. The AP stated she unplugged the heater in the resident's room and took it. The AP stated the resident then self-transferred himself from his bed to his wheelchair, followed her to the living room, and ran her over with his wheelchair which caused an injury to her thumb that required a visit to the emergency room. The AP stated she saw him throw himself out of his wheelchair. The AP stated she offered to help the resident get back in his chair, but the resident told her not to touch him. He said he was going to make sure she went to jail. The AP stated there was only one armrest on his wheelchair at that time and that was how the resident was able to transfer himself from his bed to his wheelchair. The AP stated the resident then called law enforcement and stated to them she had thrown him on the floor and dragged him. The AP stated she was not by the resident when he threw himself on the floor. The AP stated there was never a time she placed her hands on the resident in a way to cause harm, and she had never hit the resident. The AP stated the resident had a pattern of falling out of his wheelchair. The AP stated she thought the facility camera was recording, but she was unaware it had gone down during bad weather until she tried to pull the video for law enforcement. The AP stated the resident was given the option to use an electric blanket instead, which he accepted and used. After the incident, the AP stated the facility had to have two staff present to care for the resident due to his behaviors.

During an interview, a caregiver stated the resident required close supervision due to his behaviors. The caregiver stated the resident was not a reliable reporter because the resident would make up a lot of stuff and falsely reported to his family member that staff did not do something for him. The caregiver stated the resident had a lot of behaviors, used drugs, and stayed high all the time. The caregiver stated the resident refused cares and then claimed he was being abused due to cares not being done. The caregiver stated the resident would throw things at staff and had a large knife he removed from his room. The caregiver stated the resident threatened to shoot and kill someone at the facility. The caregiver stated the resident could transfer himself from his bed to his wheelchair and would throw himself on the floor from his wheelchair on purpose to tell law enforcement he was pushed him out. The caregiver stated he never witnessed the AP mistreating the resident, but the resident did call the AP names.

The resident did not return requests for an interview.

The resident's family member did not return requests for an interview.

The case manager did not return requests for an interview.

In conclusion, the Minnesota Department of Health determined abuse was inconclusive.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or 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;
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, did not respond to request.
Family/Responsible Party interviewed: No, did not respond to request.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility offered alternative warming equipment.

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
	42027	A. BUILDING: _____ B. WING _____	C 04/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDEN HOMES & CARE SERVICES LLC	18741 IVANHOE ST NW ELK RIVER, MN 55330

(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 April 21, 2026, the Minnesota Department of Health initiated an investigation of complaint HL420273522C/HL420279343M. No correction orders are issued.	0 000		