

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL201663529M
Compliance #: HL201662923C

Date Concluded: September 14, 2026

Name, Address, and County of Licensee

Investigated:

Central Minnesota Senior Care
2323 Gorton Ave SW
Willmar, MN 56201
Kandiyohi County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name:

Jana Wegener, RN, Special Investigator

Finding: Substantiated, individual responsibility

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 resident was abused when the alleged perpetrator (AP) repeatedly failed to follow the resident's behavior management plan, then argued with and yelled at the resident causing the resident increased anxiety, fear, and emotional distress.

Investigative Findings and Conclusion: The Minnesota Department of Health determined abuse was substantiated. The AP was responsible for the maltreatment. The resident had mental health diagnoses including obsessive compulsive disorder, anxiety, and hoarding. The resident had an extensive behavior plan with interventions which instructed staff on how to manage and respond to the resident's behaviors. The AP's personnel files indicated the AP was oriented to and received training on the resident's behavior plan. Despite training, the AP failed to follow the behavior plan and repeatedly engaged in arguments with and yelled at the resident in a disparaging manner causing increased anxiety, fear, and emotional distress.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's guardian. The

investigation included review of the resident record(s), outside medical records, facility internal investigation, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed residents and staff at the facility.

The resident resided in an assisted living facility with diagnoses including anxiety, agoraphobia (anxiety disorder causing intense fear of enclosed spaces, public spaces, and crowds outside of the home), irritable bowel syndrome, gastroparesis, encephalopathy, hoarding behavior, major depressive disorder, and obsessive-compulsive disorder (OCD).

The resident's assessment indicated she was dependent on assistance from staff with activities of daily living including bathing, dressing, grooming, transfers, ambulation, and behavior management.

The resident's service plan of care identified the resident required staff assistance and interventions to manage the resident's anxiety, hoarding behaviors, repetitive behaviors, resistive tendencies, and other mental health needs multiple times per day.

The resident's individual abuse prevention plan (IAPP) indicated the resident was susceptible to abuse. The IAPP indicated due to the resident's anxiety the resident was much affected by what other people thought of her, which caused the resident to become easily stressed and overly anxious. The IAPP identified the resident was particularly vulnerable to emotional abuse due to her anxiety with tendencies to become easily stressed, and desired to avoid getting others into trouble which resulted in the resident having difficulty reporting concerns.

The resident's behavior support plan initiated prior to the AP's employment indicated the resident had mental health, cognitive, or behavioral concerns requiring staff assistance with agitation, irritability, withdrawn behaviors, anxiety, repetitive behaviors, orientation, verbal aggression, self-injurious behavior, and other mental health cognitive behavioral needs. The plan indicated the resident had cognitive impairment and memory loss which affected the resident's OCD causing the resident to write down and keep track of everything. The plan indicated the resident required validation therapy, and assistance with problem-solving skills, cues, redirection, and behavior management. The plan identified the resident could become very irritable and anxious when she felt like she was not being heard by others, could not remember, or if the resident felt like she was being forced to do things. The plan indicated when the resident became irritable or anxious, she displayed varying levels of agitation, irritability, and verbal aggression. The plan indicated due to the resident's anxiety and OCD the resident was afraid anyone entering her room would take personal belongings. The plan indicated staff were trained on the resident's specific behavior plan, interventions, and how to de-escalate the resident. One of the plan's main areas of focus included concerns with the resident becoming distressed when staff tried to clean her room. The plan indicated due to OCD and hoarding tendencies the resident viewed staff attempting to clean her room as they were taking her possessions and would often refuse to let staff take dirty dishes or garbage out of her room. The plan indicated the resident hoarded dirty dishes and garbage in effort to remember

what and if she had eaten. The plan indicated when staff explained they needed to take dirty dishes or garbage out of the room the resident became anxious. The plan indicated that staff should exchange dishes when the resident was done eating and would remove two pieces of trash from her room during weekdays, then document what was removed on a sheet in the resident's room. The plan indicated when staff needed to provide care or services to the resident they should communicate to the resident in a calm, soothing, neutral voice, what they are there to assist her with, and answer any questions/concerns she may have at that time.

A concern arose when a verbal altercation between the resident and the AP was reported. The report indicated when the resident had an incontinence episode, the AP entered the resident's room and selected clothing the resident did not agree with, then the AP engaged in a verbal altercation with the resident which caused the resident to appear emotionally distressed and state she no longer wanted the AP to provide her cares.

A facility investigation into the incident indicated the facility identified the AP had a pattern of recurring conduct concern when interacting with the resident. The investigation indicated the AP had received training and coaching on her conduct with the resident but admitted having verbal confrontations with the resident. The investigation indicated the AP's interactions and response to the resident's behaviors were inconsistent with the resident's person-centered behavior plan which caused recurring emotional distress for the resident. The investigation indicated the AP emotionally abused the resident

The AP's personnel files included signed training documents indicating the AP was trained on the resident's individual behavior plan of care, services, and IAPP prior to the incident. Facility training meeting in-service notes indicated additional ongoing training was provided to the AP and other staff.

When interviewed facility leadership staff indicated the AP had not followed the resident's plan of care and entered the resident's room when she was sleeping then removed items and threw them in the trash which caused the resident distress and triggered behaviors and arguments between the resident and the AP. Leadership indicated the AP had received verbal instruction that entering the resident's room and removing items when she was not aware was against the resident's rights and her behavior plan of care. Leadership stated the AP expressed understanding but her conduct concerns continued. Leadership stated the AP entered the resident's room and cleaned out a hairbrush containing her mother's hair and threw it away which caused the resident distress because it was the last thing she had of her mother's, but expressed anxiety over reporting the concern because she did not want the AP to get into trouble. Leadership stated another verbal altercation incident occurred when the AP tried forcing the resident to eat bran cereal, but the resident did not want that cereal because it had too much fiber and would cause gastrointestinal issues, but the AP would not listen and argued with the resident. Leadership stated resident rights and choices were reviewed during a staff meeting attended by the AP. Leadership stated then one day after the resident had radiation therapy (a treatment for breast cancer) the resident had an episode of incontinence and

needed the AP's assistance. Leadership stated the AP did not give the resident a choice/option for what clean pants she would wear which resulted in another verbal altercation with the resident. Leadership stated the incident was witnessed/heard by a resident and other staff who reported the AP yelled at and arguing with the resident for several minutes, then the resident expressed she no longer wanted the AP to provide care for her. Leadership stated after they became aware of the incident the AP was suspended then terminated following the investigation. Leadership stated the resident was relieved to know the AP would no longer be at the facility but did not want the AP to get into trouble. Leadership stated the AP sent text messages indicating she felt victimized and treated poorly by the resident and indicated if the resident raised her voice at the AP, the AP would treat the resident in the same manner.

A review of text messages screen shots and email communication indicated the AP had reported to another staff that the resident was not as sweet as everyone thought she was and was actually really mean. One email communication indicated the resident appeared emotionally distressed with increased anxiety by the ongoing conflicts and verbal altercations with the AP and no longer wanted the AP to provide care for her. Text messages from the AP prior to the incident indicated the AP felt the resident treated her poorly and had yelled at her. The AP's text indicated, "if the resident was going be that way with me, I am going to treat her the same way."

When interviewed several unlicensed staff stated the resident reported the AP routinely yelled at the resident about taking her trash out, would grab it very matter of fact, and refuse to let the resident look threw it before throwing it out which caused the resident to get very upset, anxious, and feel afraid something valuable was thrown away. Staff stated the AP would frequently become upset/angry with the resident, and expressed the resident's behaviors were manipulative and demanded the resident do things a certain way, which caused the resident to feel ignored, stressed, anxious, distressed, and caused the resident to cry as a result of interactions with the AP. Staff stated the resident reported anxiety when the AP worked and feared falling asleep because the AP would come in and take her things and throw them away. Staff stated the resident frequently asked who would be working and appeared defeated when the AP was scheduled.

When interviewed a resident witness stated the day of the incident the AP was assisting the resident to the rest room and a loud verbal argument was heard between the AP and the resident. The witness indicated the AP's voice sounded angry and defensive toward the resident, and indicated the resident asked why the AP was so mean to her. The witness described the AP's interaction with the resident as forceful, threatening, and controlling. The witness stated the interaction made her feel very uncomfortable.

The attempts to interview the AP were unsuccessful.

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

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.

“Substantiated” means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

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:

(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:

(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: No, not interviewable.

Family/Responsible Party interviewed: Yes

Alleged Perpetrator interviewed: No. The attempts to interview the AP included phone, email, and subpoena.

Action taken by facility: The facility provided coaching and education to the AP, then suspended the AP pending investigation when a concern was reported. The facility reported the concern to the Minnesota Adult Abuse Reporting Center (MAARC) and investigated the incident. 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

Kandiyohi County Attorney

Willmar City Attorney

Willmar Police Department

Minnesota Department of Human Services (DHS)

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20166	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/27/2026
NAME OF PROVIDER OR SUPPLIER CENTRAL MINNESOTA SENIOR CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2323 GORTON AVENUE SW WILLMAR, MN 56201		
(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 *****ATTENTION***** HOME CARE PROVIDER/ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. 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. INITIAL COMMENTS: #HL201663529M/#HL201662923C On July 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 7 residents receiving services under the provider's Comprehensive Assisted Living license. The following correction order is issued/orders are issued #HL201663529M/#HL201662923C, tag identification 2360.	0 000	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. 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. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. 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.		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical,	02360			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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02360	Continued From page 1 sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: Based on interviews and document review, the licensee failed to ensure one of one residents (R1) reviewed was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, an individual person was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360			