Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL306311280M
Compliance #: HL306311764C

Date Concluded: April 29, 2025

Name, Address, and County of Licensee Investigated:
Edgewood EGF Senior Living
608 5th Avenue NW
East Grand Forks, MN, 56721
Polk County

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

Evaluator's Name: Angela Vatalaro, 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 alleged perpetrator (AP), an unlicensed staff member, emotionally abused the resident when responding to the resident drinking from the AP's personal cup. The AP slammed her phone down on the counter, went over to the resident said "damn you" pulled her cup aggressively away, and shoved the resident's hand away. The AP left the area screaming "your fucking disgusting, you fucking pig."

Investigative Findings and Conclusion:
The Minnesota Department of Health determined emotional abuse was substantiated. The AP was responsible for the maltreatment. Multiple staff witnessed and an audio/video recorded the AP use repeated foul language regarding the resident in the presence of the resident, other residents, and staff. The AP's repeated comments and actions would be considered humiliating, disparaging, and threatening by a reasonable person.

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

The resident resided in an assisted living memory care unit. The resident's diagnoses included Alzheimer's dementia. The resident's service plan included assistance with escorts to and from meals. The resident's care plan indicated the resident could not call for help or make sound judgements or self-direct his care. The resident was severely cognitively impaired and only oriented to self. The resident walked without a walker and was disorientated daily.

The facility's internal investigation indicated one day unlicensed personal requested leadership view recorded camera footage of the AP swearing at the resident and being very verbally aggressive. The recorded video showed at around 8:41 a.m., the AP came into the dining area and noticed the resident drinking out of the AP's water bottle. The AP slammed her phone down on the counter, walked quickly towards the resident screaming "Damn you" the resident's name. The AP aggressively took her bottle away and "shoved" the resident's hand away. The AP "stormed" out of the room screaming "you're disgusting" and "you're a pig". The AP came back to the dining area and continued to tell the resident how "gross" he was.

The facility's internal investigation included multiple staff members' written statements of the incident. Staff members stated they heard the AP say to the resident, he was a "gross ass" and "eat your fucking food" The AP continued to say to the resident "I hate him, I can't fucking stand him, he smells so fucking bad" the AP said she "hated" him, the resident was "gross" called the resident "fucken disgusting" and "you're a pig".

Review of a 49 second recorded audio and video footage from above the common dining room and angled toward the resident's dining table showed the resident seated at a table with a plate of food if front of him, without a beverage. The resident stood and walked to a nearby counter and drank from a water bottle. Two other residents were also observed seated at a different table present in the dining area. When the AP entered the dining room and saw the resident drinking from the bottle, the AP slammed down a phone on a counter, quickly walked to the resident and screamed the resident's name forcing the water bottle out of the resident's hands. The AP left the resident standing at the counter and left the room. The remaining audio from the recorded video was inaudible.

During an interview, leadership stated the video footage did not catch all the audio. Leadership conducted an internal investigation, and staff wrote out statements of the AP's comments to the resident.

During an interview, an unlicensed personnel stated earlier the same morning she and the AP were in the resident's room. The unlicensed personnel heard the AP tell the resident "I fucking

hate you" and the AP also made comments about wishing the resident was "gone." The resident was present during those comments. The water bottle incident occurred after assisting the resident in his room. During the incident, the unlicensed personnel also heard the AP tell the resident again, "I fucking hate you" and told the resident he was "disgusting." The resident was also present during those comments.

During an interview, another unlicensed personnel stated she witnessed the AP toss the resident his food plate. The plate made a "clunk" noise as the AP tossed the resident his plate. The AP told the resident "Eat your fucking food." The AP made comments about how the resident had "made out" with her water bottle and said, the resident was a "gross ass." The unlicensed personnel also heard the AP say that the resident was "fucking disgusting" and "I fucking hate him." The resident was present in the area while those comments were made.

During an interview, another unlicensed personnel stated she saw the AP toss the resident his food plate. The plate made a "clunk" noise as the AP tossed the resident his plate. The AP told the resident "Eat your fucking food." The AP made comments about how the resident had "made out" with her water bottle and said, "[resident name] gross ass." The unlicensed personnel also heard the AP say that the resident was "fucking disgusting" and "I fucking hate him." The resident was present in the area while those comments were made.

During an interview, a third unlicensed personnel stated initially she heard screaming from a female voice and responded to the dining area where the AP was serving breakfast to residents. The unlicensed personal heard the AP tell the resident he was "fucking disgusting" and this "fucking disgusting pig drank out of my water bottle" The resident was present during those comments as well as other residents in the dining room.

During an interview, a nurse stated she heard the AP tell the resident "Your fucking disgusting you fucking pig" and the AP said she had to bleach her cup because the resident was "disgusting." The resident was mainly nonverbal and remained nonverbal most days. If the resident spoke it was hard to make out his words. The nurse stated after the incident, she spoke to the resident. The resident was unable to answer any questions related to the incident for the investigation.

During an interview, the AP stated she yelled the resident's name when she witnessed the resident drinking from her water bottle. The AP stated her day was going fine until the resident drank from her water bottle. The AP stated she told the resident "That was disgusting." When asked if she ever said anything or ever acted in a way where the resident could have felt threatened, be fearful or scared, the AP said no. The AP stated she could not remember the interactions between herself and the resident. The AP stated she did not know if the incident happened and stated she did not want to say yes or say no that the incidents occurred. The AP stated she probably did say some things out of anger however, whatever was said she did not direct it to the resident.

In conclusion, the Minnesota Department of Health determined emotional 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: …
(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 reviewed video footage and conducted an internal investigation. The AP is no longer employed by the facility.

Action taken by the Minnesota Department of Health:
The facility was issued a correction order regarding the vulnerable adult’s right to be free from maltreatment.

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

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

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc:
The Office of Ombudsman for Long Term Care

The Office of Ombudsman for Mental Health and Developmental Disabilities
Polk County Attorney
East Grand Forks City Attorney
East Grand Forks Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30631	A. BUILDING: _____ B. WING _____	C 04/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD EGF SENIOR LIVING	608 5TH AVENUE NW EAST GRAND FORKS, MN 56721

(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****** 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: #HL306311764C/#HL306311280M On April 9, 2025, 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 36 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL306311764C/#HL306311280M, tag identification 2360.	0 000		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act.	02360		

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02360	Continued From page 1 This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and 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		