Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL312144163M
Compliance #: HL312148108C

Date Concluded: July 29, 2025

Name, Address, and County of Licensee Investigated:
Nagel Assisted Living
232 Elm Street South
Waconia, MN 55387
Carver County

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

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, after she had multiple teeth extracted, the alleged perpetrator (AP), facility staff, call the resident a "fucking crybaby" then told the resident to "stop fucking complaining", or the AP would pull the resident's "last tooth out".

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was substantiated. The AP was responsible for the maltreatment. The resident had a tooth extraction and when they returned back to the facility the AP called the resident a "crybaby," and told the resident to stop complaining or the AP would pull out the residents, "last tooth."

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 record(s), facility internal investigation,

personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed resident's and staff in the facility.

The resident resided in an assisted living facility memory care unit with diagnoses including schizoaffective disorder - bipolar type, altered mental status, and generalized anxiety disorder.

The resident's assessment indicated the resident had severe disorientation to person, place, and time, with hallucinations, delusions, and was unable to respond to simple questions or redirection and required frequent reminders throughout the day. The assessment indicated the resident did not have the ability to cope, make decisions, or take actions to protect herself from potentially harmful situations. The assessment indicated staff were to set limits on language (no cursing) and provide a quiet place for the resident if she became agitated.

The resident's plan of care indicated staff were to keep consistent routines, provide active listening, validate feelings, and using a calm quite voice set limits on behaviors and provide a quiet space for the resident to de-escalate.

The resident's progress notes indicated the afternoon of the incident the resident had dental surgery to extract several teeth.

The resident's medication administration record indicated she was prescribed and received pain medication for post-surgical pain at 5:30 p.m. the day of the incident.

Internal facility email communication and written staff statements indicated between 3:00 and 4:00 p.m. (after the dental procedure and prior to receiving pain medication) 2 staff reported the AP was observed and heard repeatedly tell the resident "Shut up already, why are you being a fucking crybaby", "Stop crying!", to which the resident responded, "I am not crying". The staff reported the AP continued to walk around the dining room and kept going back to the resident telling her to "Stop fucking complaining," and "stop being a fucking baby". Then, after going back and forth with the resident the AP said, "Shut up already, or I am going to take the last tooth you have left out of your mouth!" The report indicated the AP continued to repeat threats to take the resident's tooth and told the resident to "Shut up" and eat her snack. Staff indicated during the repeated verbal abuse the resident's expression changed, causing the resident to appear concerned, confused, and scared. Then, the resident asked the AP why they were being so mean to the resident. The AP did not respond and walked away.

A facility investigation indicated when leadership interviewed the AP about the allegation and reviewed direct quotes from the incident, the AP openly admitted saying those things to the resident and threatening the resident, but indicated he was joking. The facility investigation included a statement from another staff who indicated the AP had sworn at and called the resident names prior to the day of the incident, but it was not reported because no one would believe it.

When interviewed leadership stated they were not aware the incident occurred until 3 days later when they received email communication from one of the witnesses. Leadership indicated when interviewed the AP admitted swearing at the resident, calling the resident names, and threatening the resident, but did not seem to understand why his actions were inappropriate.

A review of the AP's personnel files indicated the AP had completed training on abuse, dementia, and related disorders about one month prior to the incident. A disciplinary discharge notice to the AP following the incident indicated the AP was terminated for verbally abusing the resident the day of the incident.

When interviewed one staff who witnessed the incident indicated she was shocked by what she saw and heard the AP say to the resident the day of the incident. The staff stated the AP repeatedly told the resident to "shut the fuck up, stop fucking crying, stop fucking complaining", and repeatedly called the resident "a fucking crybaby", then said, "That's it, if you don't shut up, I am going to take your last tooth out!" The staff stated with each interaction the AP became increasingly aggressive and loud toward the resident, causing the resident's facial expression to change. The staff indicated the resident appeared upset, sad, confused, and scared by the AP's statements.

Another staff stated they had witnessed the AP swear at and call the resident names the day of the incident. The staff indicated the day of the incident was not the first time the AP had used profanity and called the resident names but indicated the incident was not reported because the AP worked with a group of staff that protected each other, and no one would believe him. The staff indicated the resident appeared hurt and told the AP, "I am not a crybaby".

When interviewed the resident's family member stated the resident had a difficult painful dental procedure the day of the incident and indicated it would have been upsetting for the resident to be treated in that manner.

The AP failed to respond to interview attempts.

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: Yes
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: No, refused to respond to interview attempts (phone, email, and subpoena).

Action taken by facility:
The facility reported the incident to the Minnesota Adult Abuse Reporting Center (MAARC), suspended the AP, and investigated the incident. The AP is not longer employed by the facility.

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

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
Carver County Attorney
Waconia City Attorney
Waconia Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31214	A. BUILDING: _____ B. WING _____	C 07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NAGEL ASSISTED LIVING	232 ELM STREET SOUTH WACONIA, MN 55387

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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: #HL312144163M/#HL312148108C On July 2, 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 43 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for #HL312144163M/#HL312148108C, tag identification 0620,0730, 2310, and 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.	
0 620 SS=D	144G.42 Subd. 6 (a) / 626.557, Subd. 3 Compliance with requirements for reporting ma	0 620		

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0 620	Continued From page 1 (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. The requirement in Minnesota Statute section 626.557, Subd. 3 is: (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency.	0 620		

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0 620	Continued From page 2 (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on record review and interview facility staff failed to immediately report concerns of abuse until 3 days after the incident occurred for one of one resident, R1, reviewed. Then the facility failed to report to the Minnesota Adult Abuse Reporting Center (MAARC) until 2 days after being made aware of the incident and 5 days after the incident occurred. 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 limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).	0 620		

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0 620	Continued From page 3 Findings Include: R1 was admitted to the licensee secure memory care unit on November 19, 2020, with diagnoses including schizoaffective disorder-bipolar type, altered mental status, and generalized anxiety disorder. A facility investigation included internal email communication which included an email from unlicensed personnel (ULP)-G on June 16, 2025, at 4:45 a.m. (3 days after the incident occurred). In the email ULP-G reported concerns of verbal/emotional abuse of R1 by ULP-A which occurred on June 13, 2025, between 3:00 p.m. and 4:00 p.m. (following R1's dental procedure and prior to receiving PRN pain medication). The report indicated ULP-A was witnessed repeatedly abuse R1 by saying "Shut up already, why are you being a fucking crybaby", "Stop crying!", to which R1 responded, "I am not crying". The report indicated ULP-A continued to walk around the dining room but kept going back to R1 telling her to "Stop fucking complaining, and stop being a fucking baby". Then, after going back and forth with R1, ULP-A said, "Shut up already, or I am going to take the last tooth you have left out of your mouth!" The report indicated ULP-A continued to repeat threats to take R1's tooth and told R1 to "Shut up and eat her snack". Staff indicated during the repeated verbal abuse R1's expression changed, causing R1 to appear concerned, confused, and scared. Then, R1 asked the AP "Why are you so mean to me?", but the ULP-A did not respond and walked away. ULP-G's report indicated 2 other staff were present during the incident but did not say anything. One staff (unknown) was standing there listening to everything like nothing was going on, and the other staff (unknown) looked worried but	0 620		

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0 620	Continued From page 4 continued doing his job. The report indicated a nurse (unknown) was also present 10 feet away and did not come out of the office to see what the yelling was about. ULP-G indicated she was confused who to talk to or what to do, then spoke to ULP-I (who witnessed the incident) and indicated the abuse had been happening for a while. ULP-G asked ULP-I why he had not said anything, and ULP-I responded because the people ULP-A worked with would cover for him and it would be 3 peoples word against one, no one would believe him. The report identified 3 staff who had witnessed the abuse but cover for each other to keep out of trouble On June 18, 2025, at 12:05 p.m. (5 days after the incident occurred) Registered Nurse Director of Nursing/Licensed Assisted Living Director (RNDON/LALD)-B documented in a progress note she had notified R1's family member about an incident that occurred on June 13, 2025, where R1 was verbally abused by a staff member. MAARC report #630390680, was submitted by the licensee on June 18, 2025, at 9:50 a.m. (5 days after the incident occurred, and 2 days after being notified of the incident). The MAARC report is not part of the resident record, as a result R1's record lacked documentation of details of the incident, and what actions were taken to ensure R1 and other residents safety. A review of ULP-A's time clock punches showed ULP-A remained in the facility until the end of his shift and punched out as usual at 10:09 p.m. the day of the incident. As a result, ULP-A continued to have access to abuse R1 and other residents after staff witnessed ULP-A repeatedly abuse R1.	0 620		

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0 620	Continued From page 5 On July 2, 2025, at approximately 10:30 a.m. during an entrance conference Registered Nurse Director of Nurses/Licensed Assisted Living Director (RNDON/LALD)-B indicated they had no documentation of actions taken to prevent recurrence following the incident including education on abuse and reporting abuse following the incident because they had talked about it during shift change stand up with staff. On July 9, 2025, at 12:23 p.m. during email correspondence after the investigator requested abuse training prior to and following the incident for ULP-I and ULP-G, RNDON/LALD-B responded they had a staff meeting planned for July 24, 2025, for abuse training. A review of personnel files for abuse training for ULP-A, ULP-I, and ULP-G indicated they each had abuse training completed prior to the incident. ULP-A had abuse training completed at the time of hire on May 9, 2025, approximately one month prior to the incident. The training records for the staff who witnessed the abuse but failed to report the incident timely indicated ULP-I had completed annual abuse training on August 21, 2024, and ULP-G had completed abuse training January 21, 2025. When interviewed on July 2, 2025, at 12:11 p.m. ULP-G stated ULP-A became more aggressive in his tone of voice each time he repeated telling R1 she was a "fucking crybaby" and to "shut the fuck up", then threatened to "pull out her tooth", R1 became confused, looked scared, and her facial expression changed. ULP-G stated at first, R 1 was laughing like she thought ULP-A was joking, then R1 looked sad, confused, and scared, like what am I doing wrong? ULP-G stated she had never seen R1 respond that way to staff. ULP-G	0 620		

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0 620	Continued From page 6 indicated the incident haunted her all weekend, and she had to say something. When asked why not report the incident immediately? ULP-G responded initially, she did not know if she should report the incident or not. When interviewed on July 8, 2025, a 10:01 a.m. ULP-I stated R1 appeared upset and hurt during the verbal abuse with ULP-A and said, "I am not a crybaby". ULP-I indicated his abuse training was good and explained staff were mandated reporters of abuse, and should stop the abuse, redirect, and report it immediately. ULP-I indicated he had observed ULP-A swear at and call R1 names prior to the day of the incident, but he did not report it because ULP-A was part of a group of other staff members that protected each other, and he felt like no one would believe him. A facility policy and procedure titled "Vulnerable Adult", dated August 1, 2021, defined emotional abuse as inflicting mental pain, anguish, or distress on a vulnerable person through verbal or nonverbal acts using repeated or malicious oral, written, or gestured language (treatment that would be considered disparaging, derogatory, humiliating, harassing, threatening by a reasonable person). The policy indicated any act that constitutes maltreatment is prohibited and would be reported. The policy identified facility staff were mandated reporters of maltreatment. The policy and procedure indicated mandated reporters were required to report any actual or suspected maltreatment, abuse, or neglect immediately (defined as no longer than 24 hours from the time the incident occurred). Indicating the licensee and their staff despite being trained failed to implement and follow their policy and procedure to identify and report concerns of maltreatment of a vulnerable adult. The policy	0 620		

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0 620	Continued From page 7 failed to clearly direct staff on what steps to take if they witness or suspect maltreatment of a vulnerable adult, including stopping the abuse, and protecting the resident from recurring abuse by immediately reporting the concern. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	0 620		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to	0 730		

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0 730	Continued From page 8 the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to ensure contents of a resident record for one of one residents (R1) included documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional. 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 limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).	0 730		

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0 730	Continued From page 9 Findings Include: R1 was admitted to the licensee secure memory care unit on November 19, 2020, with diagnoses including schizoaffective disorder-bipolar type, altered mental status, and generalized anxiety disorder. A facility investigation included internal email communication which included an email from ULP-G on June 16, 2025, at 4:45 a.m. (3 days after the incident occurred). In the email ULP-G reported concerns of verbal/emotional abuse of R1 by ULP-A which occurred on June 13, 2025, between 3:00 p.m. and 4:00 p.m. (following R1's dental procedure and prior to receiving PRN pain medication). The report indicated ULP-A was witnessed repeatedly abuse R1 by saying "Shut up already, why are you being a fucking crybaby", "Stop crying!", to which R1 responded, "I am not crying". The report indicated ULP-A continued to walk around the dining room but kept going back to R1 telling her to "Stop fucking complaining, and stop being a fucking baby". Then, after going back and forth with R1, ULP-A said, "Shut up already, or I am going to take the last tooth you have left out of your mouth!" The report indicated ULP-A continued to repeat threats to take R1's tooth and told R1 to "Shut up and eat her snack". Staff indicated during the repeated verbal abuse R1's expression changed, causing R1 to appear concerned, confused, and scared. Then, R1 asked the AP "Why are you so mean to me?", but the ULP-A did not respond and walked away. ULP-G's report indicated 2 other staff were present during the incident but did not say anything. One staff (unknown) was standing there listening to everything like nothing was going on, and the other staff (unknown) looked worried but	0 730		

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0 730	Continued From page 10 continued doing his job. The report indicated a nurse (unknown) was also present 10 feet away and did not come out of the office to see what the yelling was about. ULP-G indicated she was confused who to talk to or what to do, then spoke to ULP-I (who also witnessed the incident) and indicated the abuse had been happening for a while. ULP-G asked ULP-I why he had not said anything, and ULP-I responded because the people ULP-A worked with would cover for him and it would be 3 peoples word against one, no one would believe him. MAARC report #630390680, submitted by the licensee on June 18, 2025, at 9:50 a.m. (5 days after the incident occurred, and 2 days after becoming aware of the incident). The MAARC report and internal email communication including were not part of R1's record, as a result the record lacked documentation of details of the incident, and what actions were taken to ensure R1 and other residents safety in the facility. On June 18, 2025, at 12:05 p.m. (5 days after the incident occurred) Registered Nurse Director of Nursing/Licensed Assisted Living Director (RNDON/LALD)-B documented in a progress note notifying R1's family member about an incident that occurred on June 13, 2025, where R1 was verbally abused by a staff member. There was no indication the incident was reported to R1's provider. On July 2, 2025, during entrance conference and again via email communication on July 7, 2025, at 10:44 a.m. an incident report was requested, none was provided. At 11:42 a.m. RNDON/LALD-B indicated in an email response "in hindsight an incident report should have been completed, but they thought a report to the	0 730		

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0 730	Continued From page 11 Minnesota Adult Abuse Reporting Center (MAARC) covered it". A facility policy and procedure titled "Incident Report", dated August 1, 2021, indicated any incident to a resident, visitor, staff, or to the property or grounds needs to be reported and an incident report form should be completed to document what happened. If a resident was involved in any incident, the person completing the incident report must notify the RN on-call and the Assisted Living Director, as appropriate. All incident reports related to residents will be kept in the resident records. The policy and procedure failed to indicate staff should immediately report incidents with concerns of maltreatment of a vulnerable adult to leadership. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 730		
02310 SS=G	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on record review and interview the licensee failed to ensure their vulnerable adult/incident reporting policy and procedures were implemented when they failed to ensure one of one residents (R1) was protected from	02310		

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02310	Continued From page 12 repeated verbal and emotional abuse. Although multiple staff witnessed another staff (ULP-A) repeatedly verbally abuse and threaten to physically harm R1, they failed to stop the abuse and immediately report the concern to leadership. As a result, ULP-A remained working with access to continue to abuse R1 and other residents of the facility. This harmed R1 when ULP-A swore, yelled, and humiliated the resident. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). Findings Include: R1 was admitted to the licensee secure memory care unit on November 19, 2020, with diagnoses including schizoaffective disorder-bipolar type, altered mental status, and generalized anxiety disorder. R1's assessment dated May 8, 2025, indicated R1 had slurred speech, word salad (words or phrases out of order or context and other conditions that may affect communication), and difficulty following conversations at times. The assessment indicated R1 had cognitive impairment related to mental health diagnoses causing severe disorientation to person place and time. The assessment identified R1 had delusional thoughts and socially inappropriate behaviors related to schizophrenia/psychosis and required frequent redirection. The assessment	02310		

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02310	Continued From page 13 indicated R1 had an altered mental status, anxiety, agitation, hallucinations, and was unable to respond to simple questions or redirection. The assessment indicated R1 was mentally and physically unable to make decisions or take action to protect herself from potentially harmful situations. R1's individual abuse prevention plan (IAPP) dated November 4, 2024, indicated the resident was at risk for abuse and indicated staff should give step by step instructions as needed. The IAPP indicated staff should set limits on language (no cursing) by asking R1 to return to her room if she needed and provide a quiet place if the resident became agitated. R1's plan of care effective June 13, 2025, at 9:21 a.m. prior to the incident indicated staff would encourage positive relationships with peers and staff, and indicated staff should use a person-centered approach to address R1's needs and promote dignity and sustain R1's abilities. On June 13, 2025, at 3:11 p.m. Registered Nurse (RN)-C documented in a progress note R1 had a dentist appointment in the afternoon with several teeth pulled. R1 returned with orders for antibiotics and as needed (PRN) Norco pain medication. The note indicated the electronic medical record (EMAR) was updated with medications and post-op aftercare instructions. On June 13, 2025, at 8:21 p.m. unlicensed personnel (ULP)-G documented R1 had repetitive behaviors before dinner and received PRN pain medication as soon as it arrived from the pharmacy. R1's Medication Administration Record (MAR)	02310		

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02310	Continued From page 14 indicated the resident was given the PRN pain medication at 5:30 p.m. On June 18, 2025, at 12:05 p.m. (5 days after the incident occurred) Registered Nurse Director of Nursing/Licensed Assisted Living Director (RNDON/LALD)-B documented in a progress note she had notified R1's family member about an incident that occurred on June 13, 2025, where R1 was verbally abused by a staff member. On July 2, 2025, during entrance conference and again via email communication on July 7, 2025, at 10:44 a.m. an incident report was requested, none was provided. At 11:42 a.m. RNDON/LALD-B indicated in an email response "in hindsight an incident report should have been completed, but they thought the MAARC report covered it". An email communication from ULP-G to the Human Resources Manager (HRM)-D on Sunday June 15, 2025, at 7:25 a.m. indicated ULP-G had reported concerns a resident was verbally abused and requested to have a meeting. The email failed to indicate what the concern was, who it involved or when the incident occurred. The email indicated ULP-G needed to know that if she reported the incident there would be repercussions against the staff that abused R1. ULP-G indicated the abuse incident she had observed affected her emotionally and mentally causing her to have difficulty sleeping, thinking, and working. The email indicated ULP-G would be sending another email with details of the incident. When interviewed on July 8, 2025, at 9:40 a.m. HRM-D stated although ULP-G reported	02310		

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02310	Continued From page 15 concerns of resident abuse on Sunday June 15, 2025, she did not see the email until Monday June 16, 2025, and by that time ULP-G had sent a second email with the details of the incident (below). The facility investigation included internal email communication which included an email from ULP-G on June 16, 2025, at 4:45 a.m. (3 days after the incident occurred). In the email ULP-G reported concerns of verbal and emotional abuse of R1 by ULP-A which occurred on June 13, 2025, between 3:00 p.m. and 4:00 p.m. (following R1's dental procedure and prior to receiving PRN pain medication). The report indicated ULP-A was witnessed repeatedly abuse R1 by saying "Shut up already, why are you being a fucking crybaby", "Stop crying!", to which R1 responded, "I am not crying". The report indicated ULP-A continued to walk around the dining room but kept going back to R1 telling her to "Stop fucking complaining, and stop being a fucking baby". Then, after going back and forth with R1, ULP-A said, "Shut up already, or I am going to take the last tooth you have left out of your mouth!" The report indicated ULP-A continued to repeat threats to take R1's tooth and told R1 to "Shut up and eat her snack". Staff indicated during the repeated verbal abuse R1's expression changed, causing R1 to appear concerned, confused, and scared. Then, R1 asked the AP "Why are you so mean to me?", but the ULP-A did not respond and walked away. ULP-G's report indicated 2 other staff were present during the incident but did not say anything. One staff (unknown) was standing there listening to everything like nothing was going on, and the other staff (unknown) looked worried but continued doing his job. The report indicated a nurse (unknown) was also present 10 feet away and did not come out of the office to see what the	02310		

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02310	Continued From page 16 yelling was about. ULP-G indicated she was confused who to talk to or what to do, then spoke to ULP-I (who also witnessed the incident) and ULP-I indicated the abuse had been happening for a while. ULP-G asked ULP-I why he had not said anything, and ULP-I responded because the people ULP-A worked with would cover for him and it would be 3 peoples word against one, no one would believe him. A review of MAARC report #630390680, submitted by the licensee on June 18, 2025, at 9:50 a.m. (5 days after the incident occurred, and 2 days after becoming aware of the incident). The MAARC report and internal email communications were not part of R1's record, as a result the record lacked documentation of details of the incident, and what actions were taken to ensure R1 and other residents safety in the facility. A review of ULP-A's time clock punches showed ULP-A remained in the facility until the end of his shift and punched out as usual at 10:09 p.m. the day of the incident. As a result, ULP-A continued to have access to abuse R1 and other residents after staff witnessed ULP-A repeatedly abuse R1. On July 2, 2025, at approximately 10:30 a.m. during an entrance conference RNDON/LALD-B indicated they had no documentation of actions taken to prevent recurrence following the incident including education on abuse and reporting abuse following the incident because they had talked about it during shift change stand up with staff. RNDON/LALD-B indicated staff had not reported the incident to the oncall nurse, so they were not aware the incident occurred until Monday June 16, 2025, (3 days after the incident occurred), when they saw ULP-G's emails.	02310		

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02310	Continued From page 17 RNDON/LALD-B indicated then ULP-A was suspended pending an investigation, and the incident was reported to MAARC. RNDON/LALD-B stated when HRM-D interviewed ULP-A about the incident, and reviewed exact quotes from the incident, ULP-A admitted saying those things to R1, but indicated he was joking and did not seem to understand why there was an issue or why what he did was wrong. When interviewed on July 2, 2025, at 12:11 p.m. ULP-G stated ULP-A became more aggressive in his tone of voice each time he repeatedly told R1 she was a "fucking crybaby" and to "shut the fuck up", then threatened to "pull out her tooth!" ULP-G stated R1 became confused, looked scared, and her facial expression changed. ULP-G explained at first, R1 was laughing like she thought ULP-A was joking, then R1 looked sad, confused, and scared, like what am I doing wrong? ULP-G stated she had never seen R1 respond that way to staff. ULP-G indicated the incident haunted her all weekend, and she had to say something. When asked why not report the incident immediately, ULP-G responded initially she did not know if she should report the incident or not. When interviewed on July 8, 2025, a 10:01 a.m. ULP-I stated R1 appeared upset and hurt during the verbal abuse with ULP-A and said, "I am not a crybaby". ULP-I indicated his abuse training was good and explained staff were mandated reporters of abuse, and should stop the abuse, redirect, and report it immediately. ULP-I indicated he had observed ULP-A swear at and call R1 names prior to the day of the incident, but he did not report it because ULP-A was part of a group of other staff members that protected each other, and he felt like no one would believe him.	02310		

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02310	Continued From page 18 On July 9, 2025, at 12:23 p.m. during email correspondence after the investigator requested abuse training prior to and following the incident for ULP-I and ULP-G, RNDON/LALD-B responded they had a staff meeting planned for July 24, 2025, for abuse training. A review of personnel files for abuse training for ULP-A, ULP-I, and ULP-G indicated they each had abuse training completed prior to the incident. ULP-A had abuse training completed at the time of hire on May 9, 2025, approximately one month prior to the incident. The training records for the staff who witnessed the abuse but failed to report the incident timely indicated ULP-I had completed annual abuse training on August 21, 2024, and ULP-G had completed abuse training January 21, 2025. A facility policy and procedure titled "Vulnerable Adult", dated August 1, 2021, defined emotional abuse as inflicting mental pain, anguish, or distress on a vulnerable person through verbal or nonverbal acts using repeated or malicious oral, written, or gestured language (treatment that would be considered disparaging, derogatory, humiliating, harassing, threatening by a reasonable person). The policy indicated any act that constitutes maltreatment is prohibited and would be reported. The policy identified facility staff were mandated reporters of maltreatment. The policy and procedure indicated mandated reporters were required to report any actual or suspected maltreatment, abuse, or neglect immediately (defined as no longer than 24 hours from the time the incident occurred). Indicating the licensee and their staff despite being trained failed to implement and follow their policy and procedure to identify and report concerns of	02310		

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02310	Continued From page 19 maltreatment of a vulnerable adult. The policy failed to clearly direct staff on what steps to take if they witness or suspect maltreatment of a vulnerable adult, including stopping the abuse, and protecting the resident from recurring abuse by immediately reporting the concern. A facility policy and procedure titled "Incident Report", dated August 1, 2021, indicated any incident to a resident, visitor, staff, or to the property or grounds needs to be reported and an incident report form should be completed to document what happened. If a resident was involved in any incident, the person completing the incident report must notify the RN on-call and the Assisted Living Director, as appropriate. All incident reports related to residents will be kept in the resident records. The policy and procedure failed to indicate staff should immediately report incidents with concerns of maltreatment of a vulnerable adult to leadership. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	02310		
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. 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, R1	02360		

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02360	Continued From page 20 was verbally and emotionally abused. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, a individual facility staff 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		