Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL314174902M
Compliance #: HL314171102C

Date Concluded: November 13, 2025

Name, Address, and County of Licensee Investigated:
Elmore Assisted Living
202 North Street East
Elmore, MN 56027-1007
Faribault County

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

Evaluator's Name: James Larson, 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) abused the resident when the AP hit and repeatedly yelled at the resident in retaliation for the resident's behavior and incontinence.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was substantiated. The alleged perpetrator, a facility staff member was responsible for the maltreatment. While providing incontinence care to the resident, the AP verbally reprimanded the resident and struck the resident on the hand.

The investigator conducted interviews with facility staff members, including administrative staff and nursing staff. The investigation included review of the resident record, death record, staff schedules, facility policy and procedures. The investigator also toured the facility, observed staff members interacting with residents and completing scheduled care activities.

The resident resided in an assisted living facility memory care unit. The resident's diagnoses included blindness, an irregular heart rhythm, and Post Traumatic Stress Disorder (PTSD). The resident's service plan included assistance with housekeeping, laundry as well as safety checks. The resident's assessment indicated had aggressive behaviors towards staff and was not able to communicate discomfort except moaning.

Facility documents indicated during an overnight shift the resident had an incontinent episode and required care which included replacement of bed linens and clothing. The resident was resistant to care and agitated, so the AP asked for assistance from a facility staff member. While performing the incontinence cares, the resident continued to be agitated and would not follow the AP's commands. The AP held the resident's arm and struck the back of the resident's hand twice. After completing the cares and changing the linen the AP brought the soiled linen to be laundered. The resident while lying in bed began to urinate on the bed and floor. After reentering the resident's room and witnessing the incontinence the AP began yelling and swearing loud enough that staff in other areas of the facility could hear the AP. Facility documents indicated when the AP was asked about the incident the AP reported she did tap the resident's hand a few times and grabbed his arm and shoved it back.

During an interview, the AP, stated while providing care to the resident he was becoming agitated to the point where assistance was required. Another facility staff member who was assigned to the adjacent unit assisted with the linen and clothing change. The AP stated that the resident was still being resistive and was hold on to the fasteners of his undergarments and interfering with completion of the and task. After multiple verbal requests to stop holding on to the garment, the AP stated I "took my two fingers, my pointer and my middle finger, and I tapped his hand twice." The AP stated there was no physical indication, or redness at the site after the incident.

During an interview, a facility staff member, stated while assisting the AP during the linen and garment change, she was speaking loudly and using profanity in general as well as directed at the resident. He recalled witnessing the AP striking the resident which was described as spanking a child on the back of the hand twice, in which the resident said something similar to, why did you do that? After returning to his assigned unit and finishing the scheduled shift he reported the incident to a facility administrator.

During an interview, an administrator stated a facility staff member reported the altercation and behaviors involving the AP and a resident. She was informed that he had seen the AP aggressively grab the resident's arm and had swatted his hand.

During an interview, a facility nurse stated prior to the incident the AP had been disciplined regarding conduct at work. The nurse stated during a phone call the AP admitted she had tapped the resident's hand a few times.

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: …
(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: No, unavailable for interview.
Family/Responsible Party interviewed: No, unavailable for interview.
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The facility completed an internal investigation, and disciplinary actions were taken concluding with the AP’s termination.

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
Faribault County Attorney
Elmore City Attorney
Elmore Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31417	A. BUILDING: _____ B. WING _____	C 10/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMORE ASSISTED LIVING	202 EAST NORTH STREET ELMORE, MN 56027

(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: #HL314171102C/ #HL314174902M On October 13, 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 45 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued/orders are issued for #HL314171102C/ #HL314174902M, tag identification 2360.	0 000	Assisted Living Provider 144G. 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.	

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02360	Continued From page 1	02360		
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: The facility failed to ensure one of one resident(s) reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		