

STATE LICENSING COMPLIANCE REPORT

Report #: HL304111800C

Date Concluded: June 8, 2026

Name, Address, and County of Facility

Edgewood Brainerd Senior Living ALFDC – HFID:
30411

14890 Beaver Dam Rd N,

Brainerd, MN 56401

Crow Wing County

Investigated: Using Care Predict uses a beacon to track each residents whereabouts. Electronic monitoring without policies or notifications in place.

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

Evaluator's Name: Ann Boutwell, RN
Special Investigator

The Minnesota Department of Health conducted a complaint investigation to determine compliance with state laws and rules governing the provision of care under Minnesota Statutes, Chapter 144G. The purpose of this complaint investigation was to review if facility policies and practices comply with applicable laws and rules. No maltreatment under Minnesota Statutes, Chapter 626 was alleged.

To view a copy of the correction orders, if any, please visit:

<https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html>, or call 651-201-4201 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached state form.

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30411	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/26/2026
NAME OF PROVIDER OR SUPPLIER EDGEWOOD BRAINERD SENIOR LIVIN			STREET ADDRESS, CITY, STATE, ZIP CODE 14890 BEAVER DAM ROAD BRAINERD, MN 56401		
(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 May 26, 2026, the Minnesota Department of Health initiated an investigation of complaint #HL304111800C. No correction orders are issued.	0 000			

Minnesota Department of Health

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

TITLE

(X6) DATE