Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL307388383M
Compliance #: HL307389923C

Date Concluded: February 12, 2026

Name, Address, and County of Licensee Investigated:
Edgewood Virginia I Senior Living LLC
705 17th Street North
Virginia, MN, 55792
Saint Louis County

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

Evaluator's Name: Angela Vatalaro, RN
Special Investigator

Finding: Not Substantiated

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 grabbed the resident's wrists while the resident was combative during toileting services. As a result, the resident sustained arm skin tears, and a contusion (bruise).

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was not substantiated. The resident had behaviors, and at times struck out at staff during cares. The AP stated she held onto the resident's hands, not wrists, as the resident struck out to avoid being struck. The AP stated her grip was not tight, lasted 30 seconds to one minute, the resident was still able to move her arms, and stated there was no redness afterwards. A ULP (unlicensed personnel) stated she felt the AP held the resident's wrists "a little too tight" to avoid being struck, and said the resident was able to move her arms during the AP's actions. The resident was "swatting" at the AP and the ULP during evening cares. A nurse assessed the resident, and the nurse stated there was no

redness and/or injury. In addition, the resident had a previous fall two days prior. A nurse stated the resident's bruise, and the skin tear were both related to the resident's recent fall.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident records, facility internal investigation, a personnel file, staff schedules, 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 disease. The resident's services included managing the resident's disorientation and the resident required assistance with dressing, hygiene, and toileting. The resident's assessment indicated the resident had a history of using her walker to strike others and becoming agitated with others. The resident was disoriented daily.

The facility internal investigation and progress notes indicated one day the AP and ULP were assisting the resident in the bathroom. The resident became agitated and combative during toileting cares. The ULP was present to assist and to relieve the AP for her break. The ULP indicated the resident was attempting to kick and punch the AP. The AP "grabbed" the resident's wrists "pretty hard" to the point they were "red" and was "rough" removing the resident's clothes to get her ready for bed. The AP left the area for break. When the AP left, and the ULP finished assisting the resident to bed, the resident calmed down. The ULP indicated there was a bruise on the resident's arm and a "scratch" near the resident's elbow. The resident was provided as needed medication for agitation crushed in applesauce. The resident ate half and threw the rest of the applesauce across the room. The nurse assessed the resident and the resident's skin. The resident told the nurse she was not fearful nor afraid and felt safe at the facility. The resident had a 0.1 cm x 0.1 cm skin tear above her right elbow, which was covered with a band-aid and there was also contusion on her left arm above her elbow. The nurse indicated the as needed medication was effective, and the resident was calm and relaxed during the nurse's assessment. The internal investigation indicated the bruise was an older bruise related to her falls. The AP was sent home pending investigation. During the facility internal investigation interview with the AP, the AP reported she held the resident's hands, not wrists. The resident was striking out at her during cares. Leadership had the AP demonstrate her actions by holding onto leadership's wrists in how she held the resident's hands. Leadership indicated during the demonstration the AP's action did not cause pain or redness and leadership moved her arms in a way the resident would have been during the incident.

The facility internal investigation indicated other ULP were also interviewed. They all stated they did not believe the AP would intentionally hurt or cause harm to a resident.

The resident's service delivery record and behavior charting indicated at times the resident became physically aggressive towards multiple various staff members. Examples of various actions taken by staff during these times included staff would exchange with another staff to

provide the care, call a nurse, provide as needed medication, limit sensory stimulation, assist the resident to another location, redirection, give space, and give short simple instructions.

During an interview, a ULP stated she went to assist the AP with the resident and relieve the AP for her break. While in the resident's bathroom, the ULP stated she was on the left side of the resident and the AP was in front of the resident. The resident was standing at that time. While the AP pulled the resident's pants down to change her brief, the resident was "swatting" trying to "hit" at them in a gesture as to leave her alone or leave her be. The ULP said the AP used both her hands and held onto both of the resident's hands/wrists and backed the resident up to sit on the toilet. The resident sat down. The ULP said the resident could still move her arms during the AP's actions. The ULP said the AP's grip was "a little too tight" and said it was not tight enough to cause a bruise. The ULP said the resident's wrists were a "little red" and did not remember how long they remained red; however, said they were not red for long. The ULP saw the resident the next day and said there was no redness. The ULP said during the AP's actions the resident did not voice pain or voice anything like "ow" regarding her wrists/hands. The resident was assisted into her pajamas. The resident had an open area on her arm, the size smaller than a dime, which the ULP said might have been an old scab that came off. The ULP said she applied a small round Band-Aid. The ULP stated prior to this, she had not taken care of the resident recently, so she did not know where the open skin area came from. The ULP said the resident was calm after the ULP finished dressing her and when the AP left the room. The ULP assisted the resident to bed and checked on her 30 minutes later. The resident was seen sleeping.

During an interview, the AP said a ULP came to assist her with the resident. The AP said she held onto the resident's hands when the resident struck out at her during toileting cares. The AP said at times the resident would strike out, pull hair, punch, or kick. The AP stated when she held onto the resident's hands her grip was not tight and said she held the resident's hands for 30 seconds to one minute to get the resident changed. The AP said she had worked at the facility and with the resident for years and was able to change the resident's clothes and brief in a quick fashion. The AP denied the resident had redness on her wrists.

During an interview, nurse 2 stated she received report the resident was combative during toileting services. After this report nurse 2 went to the memory care unit and assessed the resident. The AP told nurse 2 she had held onto the resident's hands, not wrists, while the resident had stuck out when the AP was changing the resident's soiled brief. The AP was sent home pending investigation. Nurse 2 said the resident did not have any redness on her wrists nor injury. The resident told nurse 2 she had no fear, was not in pain, and nurse 2 said the resident appeared calm in her room in her pajamas. Nurse 2 stated staff held onto the resident's hands while the resident was combative and striking out to ensure safety of the resident and safety of others. Nurse 2 stated prior, she had seen the AP interact with the resident and interact with other residents. Nurse 2 said the AP was very compassionate and empathetic with residents. Nurse 2 stated she had never seen the AP overly aggressive with the

resident nor with any residents. Nurse 2 stated she had no concerns with the AP's care of residents.

During an interview, nurse 1, who was also leadership staff, stated there were no concerns raised prior the incident regarding the AP's interactions with the resident or with other residents. Nurse 1 also stated she had seen the AP interact with the resident and had no concerns. Nurse 1 stated the AP demonstrated on nurse 1 how she held onto the resident. Nurse 1 said she flailed and moved her arms around in a way that the resident would have done during the incident as the AP held onto her. Nurse 1 stated she was able to move her arms with the AP's grasp, and the AP's action did not cause pain and/or redness. The day after, when nurse 1 assessed the resident, the resident told nurse 1 that no one had ever hurt her, she loved it at the facility, loved her family and friends. The resident also said no one had ever touched her without permission. When nurse 1 asked the resident about the bruise the resident denied anyone caused it and said she falls. Nurse 1 determined the bruise was older based on the color, and the skin tear was also caused from the same fall the resident had two days prior. The AP received re-education.

During an interview, nurse 3 who stated was not aware of any concerns raised prior to the incident regarding the AP's care of the resident nor care of any other residents. Nurse 3 stated the resident's behaviors were unpredictable, could be aggressive, one moment the resident would be smiling, the next moment she would swing her walker at others. Nurse 3 stated the resident had been seeing her provider regarding the behaviors. Medications were reviewed and adjustments were made. They were attempting to find a happy medium where the resident could remain as mobile as possible as well as where she would not become so angry.

In conclusion, the Minnesota Department of Health determined abuse was not substantiated.

"Not Substantiated" means:
An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment did not occur.

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:
(1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224;
(2) the use of drugs to injure or facilitate crime as defined in section 609.235;
(3) the solicitation, inducement, and promotion of prostitution as defined in section 609.322; and
(4) criminal sexual conduct in the first through fifth degrees as defined in sections 609.342 to 609.3451.
A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.

(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; or
(3) use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion, including the forced separation of the vulnerable adult from other persons against the will of the vulnerable adult or the legal representative of the vulnerable adult unless authorized under applicable licensing requirements or Minnesota Rules, chapter 9544.
(c) Any sexual contact or penetration as defined in section 609.341, between a facility staff person or a person providing services in the facility and a resident, patient, or client of that facility.
(d) The act of forcing, compelling, coercing, or enticing a vulnerable adult against the vulnerable adult's will to perform services for the advantage of another.

Vulnerable Adult interviewed: No, attempted. Unable due to cognition.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility conducted an internal investigation. The AP was provided re-education related to resident behaviors and strategies for residents with anxiety, agitation, aggressive language and behaviors, redirections, and managing caregiver stress and burnout. The AP was also assigned to work on a different side of memory care.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30738	A. BUILDING: _____ B. WING _____	C 12/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD VIRGINIA I SENIOR LIV	705 17TH STREET NORTH VIRGINIA, MN 55792

(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 December 30, 2025, the Minnesota Department of Health initiated an investigation of complaint HL307388582C/HL307387982M and HL307389923C/HL307388383M. No correction orders are issued.	0 000		