

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** H53284522M

**Date Concluded:** August 21, 2025

**Name, Address, and County of Licensee**

**Investigated:**

Parmly on the Lake LLC  
28210 Old Towne Road  
Chisago City, MN 55013  
Chisago County

**Facility Type:** Nursing Home

**Evaluator's Name:** Holly German, 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 perpetrators (AP)-1 and AP-2 abused the resident when AP-1 swore and threatened the resident and AP-2 threw a towel over the resident's head.

**Investigative Findings and Conclusion:**

The Minnesota Department of Health determined abuse was substantiated. AP-1 and AP-2 were responsible for the maltreatment. The investigation revealed staff witnessed AP-1 verbally taunt, swear at, and threaten the resident during an episode of confusion and physical aggression by the resident. The investigation revealed staff witnessed AP-2 throw a blanket over the resident's head and forcefully grab an object out of the resident's hand.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted a family member and law enforcement. The investigation included review of the resident records, hospital records, facility

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internal investigation, facility incident reports, personnel files, staff schedules, law enforcement report, and related facility policy and procedures.

The resident resided in a skilled nursing facility. The resident's diagnoses included metabolic encephalopathy (a condition where the brain's function is impaired due to metabolic or chemical imbalances in the body), and major depression. The resident's care plan included assistance with walking, toileting, behavior monitoring and de-escalation. The resident's assessment indicated the resident had altered cognition related to confusion and primarily used a wheelchair for mobility.

A facility incident report indicated staff reported the resident was combative, agitated, and swinging objects at staff. The report indicated staff reported AP-1 and AP-2 handled the situation unprofessionally and were not able to de-escalate the resident.

An internal investigation report indicated a nurse stated she heard AP-1 tell the resident he was going to jail, and AP-2 repeatedly attempted to return the resident to his unit, threw a blanket over the resident's head, and grabbed the object the resident was swinging (a wheelchair foot pedal) out of his hand. The report indicated the nurse stated AP-2 shoved the resident's head away from her to grab the foot pedal.

The same report indicated AP-1 stated the resident was angry, upset, yelling and swinging at staff. AP-1 stated the resident kept going back and forth between units yelling he wanted to get out of there. The report indicated AP-1 stated she attempted to do a pressure point technique to the resident's wrist so he would release the foot pedal, but it did not work, so she tried to lift his fingers from it.

The same report indicated AP-2 stated the resident was hitting staff with the foot pedal of his wheelchair, so she held his hands down and attempted to take the foot pedal away from him. The report indicated AP-2 stated she threw a blanket over the resident's head so she could remove the foot pedal.

The same report indicated the facility removed AP-1 and AP-2 from the facility.

During an interview, the administrator stated all staff received abuse and neglect training upon hire, annually, and as needed. The administrator stated the training included identifying forms of abuse, reporting requirements, and how to handle situations with residents. The administrator stated staff reported to her AP-1 and AP-2 did not properly de-escalate the resident and agitated him more when they attempted to get the foot pedal away from the resident. The administrator stated she had AP-1 and AP-2 demonstrate how they removed the foot pedal from the resident, and it was deemed an aggressive action that was corroborated by other witnesses. The administrator stated she expected staff to de-escalate a situation by giving the resident space, allow for them to express their feelings, remove others from the area to give the resident space and protect others, and not to contribute to the agitation.

During an interview, the director of nursing (DON) stated she received a call from the nurse who stated she had concerns about how AP-1 and AP-2 were talking to the resident, and AP-2 threw a blanket over the resident's head. The DON stated the nurse stated AP-1 was swearing at the resident and told the resident "I dare you to hit me." The DON stated when she spoke to AP-1, AP-1 denied all allegations. The DON stated when she spoke to AP-2, AP-2 stated she threw a blanket over the resident's head to be able to grab the wheelchair foot pedal from him, and she thought that was ok because it did not harm the resident. The DON stated she expected staff to give the resident space to calm down, talk him through it, and give him space to roam while ensuring he and others stayed safe. The DON stated AP-1 and AP-2 abused the resident.

During an interview, the nurse stated the night of the incident was the first time she had worked with AP-1 and AP-2. The nurse stated she heard yelling on the other unit and the resident came towards her in his wheelchair leaving that unit yelling "you have abused me enough." The nurse stated the resident had the foot pedal of his wheelchair in his hand and was swinging it at AP-1. The nurse stated she advised AP-1 to call the on-call provider for assistance. The nurse stated AP-1 stated, "I wonder if he would actually hit me" and continued to try to reach for the foot pedal from the resident. The nurse stated AP-2 approached her and the resident while she attempted to calm the resident, and the nurse told AP-2 to go away. The nurse stated AP-2 replied, "not on my unit" and lunged toward the resident in attempt to remove the foot pedal. The nurse stated AP-2 threw a blanket over the resident's head, pushed his head to the side, and grabbed the pedal from him with force as the resident's arm was extended up and almost behind him. The nurse stated she yelled at AP-2 to get away from him and to go get the nurse. The nurse stated AP-1 came and yelled at the resident "you are going jail, you are fucking going to jail, fucker," and yanked the resident forward and backward in his wheelchair by the sleeve of his shirt near the shoulder before walking away. The nurse stated she tried to talk to the resident, tell him he was safe with her, and the resident sat in his chair and cried. The nurse stated the resident's fingers looked swollen and purple, and his hand had a large bruise that she did not know if it was there previously.

During an interview, AP-1 stated she received abuse and neglect training during her orientation via training videos and on the floor training with another nurse. AP-1 stated the night of the incident, the resident went to another unit. AP-2 was mad the resident was on her unit and told AP-1 to get him out of her unit. AP-1 stated she could not get the resident to return to his unit and he swung his wheelchair foot pedal at her every time she got close to him. AP-1 stated she attempted to get the resident to release the foot pedal by applying a pressure point technique to the resident's wrist, that did not work, so she pulled up on it and he let go. AP-1 stated she did not believe she did anything abusive to the resident. AP-1 denied she used swear words, called the resident names or threatened him.

During an interview, AP-2 stated she has been a caregiver for many years, and received training on abuse and neglect through videos and learning on the computer. AP-2 stated she was not

assigned to care for the resident, had not previously worked with the resident, and was not aware of his care needs the night of the incident. AP-2 stated she did not force any objects from the resident's hand, and did not throw a blanket over the resident's head. AP-2 stated she threw a blanket in the resident's lap, and the managerial staff who interviewed her previously must have misunderstood her. AP-2 stated she did not use cuss words or made threats to the resident, and did not hear anyone else do that either. AP-2 stated she was not aware of any actions taking place towards the resident that others may deem inappropriate.

During an interview, a family member stated the staff did not know how to handle the resident at that time, as the resident had just woken up from a bad dream and was acting up. The family member stated the resident was fine, had no injury, and the resident was much better now since he has settled in at the facility. The family member stated the facility takes good care of the resident.

The resident could not complete an interview due to his cognitive status and inability to recall the incident.

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:

(1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224;

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.

**Mitigating Factors considered, Minnesota Statutes, section 626.557, Subd. 9c(f):**

(1) AP-1 and AP-2 did not follow an erroneous order, direction or care plan with awareness and failure to take action.

(2) The facility was in compliance with regulatory standards.

The facility provided proper training and/or supervision of staff.

The facility provided adequate staffing levels.

AP-1 and AP-2 failed to follow the facility directive and/or policies and procedures.

(3) AP-1 and AP-2 failed to follow professional standards and/or exercise professional judgement.

AP-1 and AP-2 failed to act in good faith interest of the vulnerable adult.

The maltreatment was a sudden or foreseen event.

**Vulnerable Adult interviewed:** No, unable to complete an interview

**Family/Responsible Party interviewed:** Yes.

**Alleged Perpetrator interviewed:** Yes.

**Action taken by facility:**

The facility investigated the incident and both AP's are no longer at the facility.

**Action taken by the Minnesota Department of Health:**

MDH previously investigated the issue during a standard abbreviated survey under 42 CFR 483, Subpart B, Requirement for Long Term Care facilities, and substantiated facility 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>

The purpose of this investigation was to determine any individual responsibility for alleged maltreatment under Minn. Stat. 626.557, the Maltreatment of Vulnerable Adults Act.

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

Chisago County Attorney  
Chisago City City Attorney  
Chisago City Police Department  
Minnesota Board of Nursing

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Minnesota State Department of Health

<b>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</b>	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED <b>07/21/2025</b>
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NAME OF PROVIDER OR SUPPLIER <b>Parmly on the Lake LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>28210 OLD TOWNE ROAD , CHISAGO CITY, Minnesota, 55013</b>
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(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) COMPLETION DATE
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20000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>NH LICENSING CORRECTION ORDER</p> <p>In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.</p> <p>Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.</p> <p>You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.</p> <p>INITIAL COMMENTS:</p> <p>The Minnesota Department of Health investigated an allegation of maltreatment, complaint #H53284522M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557.</p> <p>The following correction order is issued/orders are issued for #H53284522M, tag identification 21850.</p>	20000	<p style="font-size: 48px; transform: rotate(-45deg); opacity: 0.5;">REQUEST FOR RECONSIDERATION RECEIVED</p>	
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Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Minnesota State Department of Health

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NAME OF PROVIDER OR SUPPLIER <b>Parmly on the Lake LLC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>28210 OLD TOWNE ROAD , CHISAGO CITY, Minnesota, 55013</b>	
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20000	Continued from page 1  The facility has agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <a href="http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm">http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</a> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "reviewed" in the box available for text. Then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.	20000	<b>REQUEST FOR RECONSIDERATION RECEIVED</b>	
21850	<p>Patients &amp; Residents of HC Fac. Bill of Rights</p> <p>CFR(s): MN St. Statute 144.651 Subd. 14</p> <p>Subd. 14. Freedom from maltreatment. Residents shall be free from maltreatment as defined in the Vulnerable Adults Protection Act. "Maltreatment" means conduct described in section 626.5572, subdivision 15, or the intentional and non-therapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. Every resident shall also be free from non-therapeutic chemical and physical restraints, except in fully documented emergencies, or as authorized in writing after examination by a resident's physician for a specified and limited period of time, and only when necessary to protect the resident from self-injury or injury to others.</p> <p>This LICENSURE REQUIREMENT is NOT MET as evidenced by:</p> <p>The facility failed to ensure one of one resident(s) reviewed (R1) was free from maltreatment.</p> <p>The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and individual persons were responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.</p>	21850		