Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H54342821M
Compliance #: H54348641C

Date Concluded: June 8, 2026

Name, Address, and County of Licensee Investigated:
Bethany on the Lake
1020 Lark Street
Alexandria, MN 56308
Douglas County

Facility Type: Nursing Home

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 alleged perpetrator (AP) abused the resident when the AP repeatedly yelled at and threatened the resident in a loud aggressive tone.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was substantiated. The AP was responsible for the maltreatment. Two unlicensed personnel (ULP-1 and ULP-2) witnessed the AP repeatedly using threatening language towards the resident. The resident record showed the resident had a decline in food intake, refused meals, and had increased behaviors following the incident requiring transfer to the emergency department.

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), hospital records, facility internal

investigation, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator reviewed previous federal investigation documentation.

The resident resided in a skilled nursing facility with diagnoses including Alzheimer's disease with late onset, depression, dementia with other behavioral disturbances, psychotic disorder with delusions, chronic pain, and generalized anxiety disorder. The resident's assessment at the time of the incident indicated the resident had moderate cognitive impairment.

The resident's plan of care identified she had alterations in behavior including wandering, yelling, resistance to cares, and combative conduct towards staff. Interventions included allowing the resident time to communicate needs, calling the resident's family, offering food/fluids, toileting, repositioning, approaching with a calm voice making eye contact and using therapeutic touch, validating the resident's feelings, and providing emotional support. The plan of care indicated the resident required two staff for transfers using a mechanical standing lift.

A review of the resident's meal intake indicated in the 12 days prior to the incident the resident generally consumed at least 25 % of meals with only one meal refusal noted.

A facility investigation included interviews with two ULP witnesses. ULP-1's statement indicated the resident was crying while talking to her son on the phone. During that time, the AP responded to the resident in a gentle, kind manner, but when the call ended it was like a switch flipped then the AP yelled at the resident "Stop crying, you're acting like a two-year-old!" ULP-1 indicated the AP aggressively grabbed the resident's arms and applied a lift sling to connect the resident to a mechanical standing lift, to which the resident responded by swatting at the AP. ULP-1 indicated the AP stated in a stern voice to the resident, "If you hit me again, I am going to hit you back!" ULP-1 indicated the AP then called for another staff to assist with transferring the resident. ULP-1 indicated the resident continued to cry. Then the AP threatened to put the resident in a locked unit in the basement "where she would never get out." At that time another resident call light went off, so the two ULP's instructed the AP to leave the room and answer the other resident's light. ULP-1 indicated when the AP returned about five minutes later she told the resident she should be "grateful" they were taking care of her and that no one wanted to work with her, because no one wanted to work with a "crybaby." ULP-2's statement indicated she was called to the room to assist the AP with a resident who was being "combative." ULP-2 indicated when she entered the room the AP was yelling at the resident "Stop crying, you're going to be a Hoyer if you do not stand!" ULP-2's statement indicated after the AP left the resident's room the ULP's attempted to comfort the resident by apologizing for the AP's conduct, but the resident continued to cry. ULP-2 indicated the AP's interactions with the resident were verbally abusive and the incident was reported to the nurse. The facility investigative report findings indicated when interviewed the AP admitted feeling frustrated with the resident crying, and threatened to hit the resident, but indicated she made the comment without thinking and would never hit a resident.

Following the incident, the resident's overall meal intake decreased with an increase of five meal refusals over the next 4 days following the incident.

A review of the resident's behavior documentation indicated although the resident had behaviors including expression of sadness and yelling out prior to the incident, her behavior increased in severity and frequency becoming more aggressive following the incident.

Two days after the incident occurred the resident required transfer to the emergency department (ED) for behavior management. The residents ED after visit summary indicated the resident was seen for increased agitation/aggressive behaviors with poor food intake, refusing medications, and meals. The resident was noted to have low blood glucose requiring intravenous fluids with dextrose and was given sedative medications to help manage her behaviors.

When interviewed, facility leadership stated the two ULP's who witnessed the incident reported the AP repeatedly yelled at the resident in an aggressive tone, then threatened to hit and lock the resident up. Leadership indicated the resident had increased behaviors and refused to eat after the incident occurred requiring medical attention.

When interviewed, ULP-1's statement was consistent with their previous facility interview statement. ULP-1 stated while the resident was on the phone talking to her son she was crying because she "wanted to go home." ULP-1 indicated the AP's statements toward the resident were aggressive and threatening.

When interviewed, ULP-2's statement was consistent with their previous facility interview statement. ULP-2 stated when she entered the room the AP was witnessed repeatedly berating the resident in a harsh demanding tone to "hold on" and "stop crying" because "no one wants to take care of a crybaby." ULP-2 stated the AP's statements were mean and nasty toward the resident which caused the resident to appear visibly upset and fearful during the interactions with the AP.

When interviewed, the AP admitted blurting out statements in a loud tone over the resident's crying for her to "stop crying," and something like, "Don't hit me I don't want to hit you back." The AP indicated she would never harm a resident and denied making other threatening statements toward the resident.

When interviewed, the resident's family member stated the resident stopped eating and her behaviors increased requiring transfer to the ED after the verbal abuse from the AP.

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:
(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, not interviewable.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The two ULP’s who witnessed the incident immediately reported the incident to the nurse. The facility investigated the incident and suspended the AP. The AP is no longer employed by 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
Douglas County Attorney

Alexandria City Attorney
Alexandria Police Department

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **05/06/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethany On The Lake LLC	**1020 LARK STREET , ALEXANDRIA, Minnesota, 56308**

(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
20000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER 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. 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. 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. INITIAL COMMENTS: The Minnesota Department of Health investigated an allegation of maltreatment, complaint #H54342821M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. The following correction order is issued for #H54342821M, tag identification 21850. The facility has agreed to participate in the	20000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

Minnesota Department of Health

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20000	Continued from page 1 electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm 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		
21850	Patients & Residents of HC Fac.Bill of Rights CFR(s): MN St. Statute 144.651 Subd. 14 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. This LICENSURE REQUIREMENT is NOT MET as evidenced by: The facility failed to ensure one of one residents reviewed (R1) was free from maltreatment. The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual person was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	21850		