Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL205349862M
Compliance #: HL205344540C

Date Concluded: April 20, 2026

Name, Address, and County of Licensee Investigated:
The Oaks Whispering Pines Assisted Living
2201 7th Ave N
Anoka, MN 55303
Anoka County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Lori Pokela R.N.
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 facility neglected the resident when staff administered an overdose of pain medication, then the resident slid out of a chair onto the floor and sustained a fracture to her right humorous [upper arm bone].

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although the resident overdosed, staff attempted to clarify two orders for the resident's pain medication, [Oxycodone]. While staff attempted to clarify the resident's orders, staff administered the resident's long-standing order for pain medication, monitored the resident and when the resident had a change in condition, staff immediately treated the resident with Narcan, called 911 and was transported to the hospital for evaluation. Additionally, the resident was treated at the hospital for a fracture to her right humorous and returned to the facility at her baseline health status.

The investigator conducted interviews with facility staff members, including administrative and facility nursing staff. The investigator contacted the resident's hospital nursing staff. The investigation included review of the resident record(s), hospital records, facility incident reports, personnel files, staff schedules and related facility policy and procedures. Also, the investigator observed the facility environment, medication administration, cares and staff interaction with the resident.

The resident resided in an assisted living facility. The resident's diagnoses included cerebral vascular accident, (stroke), small cell lung cancer and fracture of the right humorous bone. The resident's service plan included staff assistance with medication administration, activities of daily living, (ADLs) and daily behavior monitoring. The resident's assessment indicated the resident had a history of depression and substance abuse, such as hiding her Oxycodone medication, and staff were to ensure all medications were swallowed during administration.

The resident returned to the facility following gallbladder surgery with two orders for Oxycodone. The long-standing order was prescribed for Oxycodone 20 milligram (mg) tablet for cancer pain and Oxycodone 5-10 mg tablet for post-operative pain, both to be administered every four hours as needed (PRN). A facility nurse attempted to clarify the orders with the resident's medical providers. While the facility nurse awaited clarification of the two Oxycodone orders, staff continued to administer the long-standing as prescribed.

The resident's medical records indicated the resident was monitored and approximately one and a half days after the resident's post-operative procedure, the resident became lethargic then slid out of her chair. Two nurses assessed the resident, then a facility nurse administered Narcan to the resident while 911 was being called. The resident was transported to the hospital for further evaluation.

While at the hospital, the resident was diagnosed with an unintentional overdose and fracture of her right humorous bone. The resident was treated and transported back to the facility three days later with orders to continue the PRN Oxycodone 20 mg. The 5 mg Oxycodone was discontinued.

During an interview, the facility nurse stated when the resident returned with the new PRN Oxycodone 5mg order and medication she instructed staff not to administer it. The facility nurse stated the next morning she called the resident's surgical triage nurse and oncologist to clarify the order. The facility nurse stated she informed the resident's surgical nurse that the new PRN Oxycodone order would be held. The facility nurse stated the resident's surgeon's office never returned the call. The facility nurse stated the resident's primary provider visited the resident the day after the resident returned to the facility and was updated regarding the Oxycodone orders, a hold placed on the new Oxycodone orders with the need for clarification. The facility nurse stated she was present the morning the resident fell and recalled the resident was very sleepy but refused to lie down. The facility nurse stated after the resident was transferred back into her chair via mechanical lift with assistance of three staff, the resident

“passed out” and would not wake up. The facility nurse stated even though she knew the resident was administered the Oxycodone as prescribed she recalled that it was not usual for the resident to request the medication on the night shift and so both the administrative and the facility nurse decided to administer the Narcan and call 911.

During an interview, an administrative nurse stated both the administrative and facility nurse decided to place the hold on the additional PRN Oxycodone 5mg because the order was never initiated, they were awaiting clarification, and the facility did not administer dose ranges as prescribed in the new order.

During an interview, the resident’s hospital nurse stated she identified that the resident’s PRN Oxycodone did not have perimeters and that it may have been better to administer the lower dose of the PRN Oxycodone to the resident.

In conclusion, the Minnesota Department of Health determined neglect 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.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
“Neglect” means neglect by a caregiver or self-neglect.
(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.

Vulnerable Adult interviewed: No, resident declined to be interviewed.
Family/Responsible Party interviewed: No, resident was responsible for self.
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
The facility attempted to clarify the narcotic pain medication orders and continued with previously scheduled medication. The facility monitored and assessed the resident’s condition and intervened when a change in condition was observed.

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
	20534	A. BUILDING: _____ B. WING _____	C 02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKS	2201 7TH AVENUE NORTH ANOKA, MN 55303

(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 February 12, 2026, the Minnesota Department of Health initiated an investigation of complaint #HL205344540C/#HL205349862M. No correction orders are issued.	0 000		