Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL282275622M
Compliance #: HL282273220C

Date Concluded: February 18, 2025

Name, Address, and County of Licensee Investigated:
Oak Park Senior Living
13936 Lower 59th Street
Oak Park Heights, MN 55082
Washington County

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

Evaluator's Name: Christine Bluhm, RN
Special Investigator

Finding: Inconclusive

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: The alleged perpetrator (AP) abused the resident when she scratched and left marks on the resident's hands after she tried to reset the resident's call pendant away from him prior to completing cares. The AP also shook her fist at the resident.

Investigative Findings and Conclusion: The Minnesota Department of Health determined whether abuse occurred was inconclusive. The resident did have visible marks on her skin which likely occurred when the AP and the resident hands grappled over the AP's name tag and the call pendant. However, the investigation did not identify evidence to show this incident met the definition of abuse or a potential error in therapeutic conduct on behalf of the AP. The accounts of the two people present, while generally the same, included inconsistencies which led to a determination of inconclusive.

The investigator conducted interviews with facility staff members, including nursing staff and unlicensed staff. The investigation included a review of the resident record, facility internal investigation, facility incident reports, personnel files, staff schedules, and related facility policy

and procedures. Also, the investigator observed resident and staff interactions and general activities during a recent visit to the facility.

The resident resided in an assisted living memory care unit. The resident's diagnoses included traumatic brain injury-induced dementia and heart failure. The resident's service plan included assistance with medications, and all activities of daily living; bathing, personal hygiene, catheter care, laundry, meals, housekeeping, behavior interventions and every two-hour safety checks. The resident's assessment indicated he used a walker for mobility and had moderate memory impairment with behaviors associated to his dementia diagnosis.

Review of a concern indicated that the AP tried to take the call pendant out of the resident's hands by pulling it, which caused scratches and bruising to the resident's hands and the metal clamp on the pendant to bend. The concern also indicated the AP shook her fist back at the resident and stated "do you see my fist" after he shook his fist at her.

Review of photos taken the day of the incident show scratches and broken skin on both the residents hands as well as a bent metal clamp on the call pendant.

Review of the AP's written statement indicated that night she gave the resident his medications and then tried to change his urinary bag when the resident became verbally aggressive, started name calling and grabbed the AP's name tag when she tried turning off the pendant.

Review of the pendant call activity log indicated the resident pressed the call pendant at 19:51 and it was cleared by the AP at 20:07, after a total of 16 minutes and 32 seconds.

During interview with the investigator, the AP stated she attempted to change the resident's urinary bag, when he became upset and grabbed her name tag. She said while the resident had held her name tag, she held his hand in an effort to stop the badge reel on the name tag from coming loose and hitting her or the resident. The AP stated that she wanted to turn the call pendant off because the nurse would call assuming the call pendant had been going off for so long. The AP admitted she tried to reset the pendant while the resident had it in his hand. She stated that when she bent down to turn it off, the resident went into defense mode and thought she was trying to take his call pendant and that is when it escalated. She stated she grabbed his arms at the wrist and told the resident to let go of her name tag.

During an interview, another caregiver stated she did not witness the incident but did hear commotion from the resident's room when she passed by the room at one point. The AP told the caregiver that the resident grabbed her name tag and would not let go and that she had to grab the resident's hands to get him off of her. After the incident the caregiver stated she looked at the resident's hands and noted they were bleeding, so she advised the AP to call the nurse and report what had occurred.

During an interview, a nurse manager stated that staff are expected to answer resident calls within five minutes, and an alert will go out to management if a pendant call has not been answered after 15 minutes. If there is a case where the pendant cannot be reset in person, staff are to call, and management can reset it remotely. The nurse stated that this resident requests staff to complete cares before they reset his pendant, so the thought was that the AP tried to reset the pendant first, and a struggle ensued. The AP told the nurse it was the name tag the resident grabbed, and she tried to get him to let go. The resident stated the struggle was over the pendant that she tried to take and reset. The nurse stated whether it was the pendant or name tag, the AP used poor judgement and should have stopped and called the nurse with the issue.

During interview, a family member stated that it was concerning that there is pressure put on staff to reset the call pendant within so many minutes. The family member said clearing the pendant with a dementia resident should not end in a physical altercation. He believed the pendant's metal clasp (which was bent and damaged) likely cut the skin on the resident's hands during the struggle.

In conclusion, the Minnesota Department of Health determined abuse was inconclusive.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or 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.

Vulnerable Adult interviewed: Yes.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility: The AP was removed from the schedule during an internal investigation. The AP no longer works at the facility. A review of vulnerable adult training and expectations was reviewed with all staff after the incident.

Action taken by the Minnesota Department of Health: No action 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
	28227	A. BUILDING: _____ B. WING _____	C 11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK PARK SENIOR LIVING	13936 LOWER 59TH STREET NORTH OAK PARK HEIGHTS, MN 55082

(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 ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL282275622M / HL282273220C and #HL282276122M / HL282274540C On November 20, 2025, the Minnesota Department of Health initiated a complaint investigation at the above provider. No correction orders were issued.	0 000	fMinnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	