Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL305471500M
Compliance #: HL305476120C

Date Concluded: April 21, 2026

Name, Address, and County of Licensee Investigated:
Lake Song Assisted Living
206 Crosier Drive North
Onamia, MN 56359
Mille Lacs County

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

Evaluator's Name: Ann Boutwell, RN
Special Investigator,
Katherine Barnhardt, 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), facility unlicensed staff, neglected the resident when the AP did not follow the plan of care and the resident fell resulting in death.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The AP was not responsible for the maltreatment. The AP followed the resident's plan of care. The resident's care plan directed unlicensed staff to allow the resident time and reapproach when the resident was agitated. When the AP offered toileting assistance to the resident, the resident became agitated, and the resident declined assistance. The AP told the resident she would return to check on her. When the AP returned, the resident was on the floor not breathing. Emergency services were called, and the resident was pronounced deceased.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted a hospice agency and a family member. The investigation included review of the resident records, death record, hospital records, pharmacy records, facility internal investigation, personnel files, staff schedules, law enforcement report, emergency service transcripts and related facility policy and procedures. Also, the investigator observed unlicensed staff provide direct care to residents.

The resident resided in an assisted living memory care unit. The resident's diagnoses included Alzheimer's disease and coronary artery disease (narrowing of the arteries). The resident's service plan included assistance with toileting seven times daily and cueing with tasks. The resident's assessment indicated resident utilized a four-wheel walker and wheelchair with assistance for long distances. The assessment indicated at times the resident toileted and transferred independently. The resident had a history of agitation with cares, and unlicensed staff were directed to allow the resident time and reapproach. The resident was a do not resuscitate (DNR).

The residents record indicated the resident was assisted to the bathroom by the AP and a second unlicensed staff, the resident became agitated and refused assistance. The unlicensed staff informed the resident they would return when unlicensed staff exited the resident's bathroom. The resident remained in the bathroom sitting on the toilet with pants up. The AP returned within forty-five minutes and found the resident lying on the bathroom floor not breathing. The AP summoned a second unlicensed staff to assist, and the AP called hospice triage and emergency services.

Emergency medical services (EMS) arrived, and the resident was unresponsive. The EMS report indicated the resident was pronounced deceased.

The resident's camera footage included audio. The video indicated the resident was assisted to the bathroom by the AP and a second unlicensed staff. Water was heard running in the background, and the AP was heard offering the resident a sip of water. The AP then asked the resident if she was feeling better and the resident replied yes. The AP asked the resident if she would stand up for the AP and the resident replied not yet. The AP tells the resident she will come back a little later and the apartment door is heard shutting. After the AP exited the room, the resident can be heard coughing and minutes later a loud noise coming from the bathroom. Thirty-nine minutes later the AP and a second unlicensed staff were observed entering the bathroom and phoning 911.

The resident's death record indicated cause of death was chronic diastolic congestive heart failure and coronary artery disease.

During an interview, licensed staff stated the resident was independent with walking in her apartment and received assistance with toileting from staff. However, the resident randomly toileted herself without asking for assistance and would refuse assistance from staff. The

resident would become agitated at times, and unlicensed staff were directed to reapproach. Licensed staff stated there was an emergency pull cord on the wall to the left of the resident's toilet and a sign reminding the resident to use the pull cord for assistance.

During an interview, the AP stated on the day of the fall, she assisted the resident back into her apartment to use the bathroom. The resident sat on the toilet with her pants up, and the AP asked the resident to stand up to lower her pants, and resident stated no. After several attempts were made to assist the resident, the resident became agitated. The AP told the resident she would return and left the bathroom. When the AP returned, the resident was found lying on the bathroom floor. The AP summoned a second unlicensed staff, called 911, and hospice. The AP stated emergency services and licensed hospice staff arrived and contacted family.

During an interview, a family member stated there were no care concerns prior to the incident and the resident walked independently with a walker in her room. Family placed a camera with audio in the main living area of the apartment; however, it did not cover the bathroom. The resident fell asleep easily, had gotten weaker, and needed reminders for toileting. A family member stated the resident's fall could be heard on audio.

The investigator attempted to reach a hospice licensed staff and a witness to the incident, however neither responded to requests for interview.

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 interviewed: No, deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:

The facility completed an internal investigation and held an all staff meeting to review the incident and emergency processes.

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
	30547	A. BUILDING: _____ B. WING _____	C 03/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE SONG ASSISTED LIVING	206 CROSIER DRIVE NORTH ONAMIA, MN 56359

(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 March 10, 2026, the Minnesota Department of Health initiated an investigation of complaint #HL305476120C/#HL305471500M. No correction orders are issued.	0 000	Minnesota 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.	