Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL305992801M
Compliance #: HL305991137C

Date Concluded: June 8, 2026

Name, Address, and County of Licensee Investigated:
Whispering Oak Place
903 Calverly Court
Ellendale, MN 56026
Steele County

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

Evaluator's Name:
Lacey Eggersdorfer, RN
Special Investigator

Finding: Substantiated, facility 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) an unlicensed staff neglected the resident when the resident had increasing, untreated pain for eight hours.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The resident reported to the AP multiple times he had stomach and back pain, which was new for the resident. The AP did not notify the nurse or treat the residents pain during the AP's 8 hour shift. When the morning staff arrived they assessed the resident and contacted 911. When emergency medical services arrived, the resident passed away. The residents death certificate indicated the residents cause of death was heart failure (a chronic condition where the heart muscle is too weak or stiff to pump blood efficiently). The AP, an unlicensed staff, was not trained by the facility on managing residents pain, recognizing a change of condition, and when to notify the nurse.

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

The resident resided in an assisted living facility. The resident's diagnoses included hypertensive heart disease with heart failure, atrial fibrillation, and gallstones. The resident's service plan included assistance in pain relief. The resident's assessment indicated he was oriented and wheelchair bound.

An incident report indicated the resident complained of stomach pain since before the evening meal. The AP advised the resident to press his call light if he had continued pain in a couple of hours. The resident pressed his call pendent early the next morning two hours before the shift changed and the AP reported when the resident called, he had continued complaints of stomach pain and new complaints of back pain. The resident was told he could have more Tylenol later in the morning and the resident was left in his room. When an unlicensed staff arrived, the resident complained of bad pain, was holding his abdomen, and sweating while rocking back and forth in distress. An unlicensed staff took the resident's vitals and found them to be elevated. The manager and a triage nurse were notified and advised the staff to call 911.

The emergency medical service report indicated the resident was alert, orientated, and sweaty. He was holding his lower stomach, breathing heavily and stated his groin and lower stomach were in pain. The resident reported he had been sitting in his wheelchair in pain for approximately four and a half hours. The resident stated he could not take the pain anymore, bent forward and vomited. The resident went unconscious and emergency medical personnel did not find pulses and agonal breathing (an abnormal, reflexive gasping pattern that is a critical medical emergency) was noted. An unlicensed staff could not provide the code status and CPR was started however the resident was pronounced deceased at the facility.

The resident's death record indicated the resident died from acute on chronic congestive heart failure.

Facility documents indicated that the resident complained of pain on the night shift three times and the AP did not provide interventions for the resident or escalate concerns to a nurse or provider. The facility lacked evidence the AP had any education in her personnel file throughout the approximately two years the AP worked at the facility.

During an interview, the AP stated the resident complained of stomach pain and she told him to press his call pendent in a few hours if he didn't feel better. The AP stated he did press his call pendent again early the next morning and complained of back pain at that time as well. The AP did not take vital signs and she did not believe he looked in distress. When asked about training, she stated she did not receive any training in changes of condition or emergencies. The AP stated she missed the last annual training and that she was aware that the facility had no record

of her training since she started working there 2 years ago. The AP stated the nurse did reach out to reschedule training but nothing was set up.

During an interview, the nurse stated any complaint requiring a nursing assessment, such as pain, should be reported to the nurse on site or to the afterhours triage line. If there were complaints of pain, the staff were to check vital signs. The nurse stated training staff involved onboarding training, shadowing of other staff, and a written exam with a skills checklist. After onboarding training, staff are assigned computer modules and must complete annual training. The nurse stated The AP did not have education completed prior to the incident.

During an interview, the manager stated The AP did not follow the facility process when the resident was in pain however the AP was not up to date on training, specifically that there was no training for the last two years. The manager stated since the incident the AP was retrained.

During an interview, a family member stated he did not know anything regarding the incident and was not told what happened. A family member stated he did not even know the cause of the resident's death.

In conclusion, the Minnesota Department of Health determined neglect 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.

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, deceased.
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
Emergency medical services were called, and the facility did an internal investigation.

Action taken by the Minnesota Department of Health:
The responsible party will be notified of their right to appeal the maltreatment finding.

The facility was found to be in 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

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

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Steele County Attorney
Ellendale City Attorney
Steele County Sheriff
Steele County Medical Examiner

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30599	A. BUILDING: _____ B. WING _____	C 04/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHISPERING OAK PLACE	903 CALVERLY COURT ELLENDALE, MN 56026

(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****** HOME CARE PROVIDER/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: #HL305991137C/#HL305992801M On April 28, 2026, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 30 residents receiving services under the provider ' s Assisted Living with Dementia Care license.	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	

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0 000	Continued From page 1 The following correction order is issued/orders are issued for ##HL305991137C/#HL305992801M, tag identification 2360.	0 000	ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident(s) reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		