Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL305997324M
Compliance #: HL305992520C

Date Concluded: February 27, 2025

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: 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 the AP took the resident by her arm to her room after an incident. This resident sustained two bruises on her arm.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse occurred was inconclusive. While it was true the interaction between the AP and resident likely caused a bruise on the resident's arm, it was in the context of the resident swinging to hit the AP. The AP then walked the resident to her apartment while holding her arm in an effort to calm her down.

The investigator conducted interviews with facility staff members. The investigation included 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's during day activities and staff interactions with them during a visit to the facility.

The resident resided in an assisted living facility. The resident's diagnoses included mild cognitive impairment and vitamin B12 deficiency (which increases the risk of bruising). The resident's service plan included assistance with medication administration and reminders with personal hygiene. The resident's assessment indicated she had difficulty with memory and displayed deficit in judgement.

The nursing progress notes indicated the resident got upset with the AP, who worked in the activities department, swung out and hit him in the face. The AP then escorted the resident back to her room in an effort to calm her down. The nursing notes indicated the resident's primary doctor was contacted regarding a bruise to her upper right arm.

An employee counseling note indicated the AP reported an incident when the resident became angry, hit at the AP, and threw a bag of crackers at him. The AP attempted to verbally redirect the resident, however when the resident hit out at the AP, he tried to stop the resident from hitting him and walked the resident to her apartment. The AP received verbal coaching after the incident.

The AP gave a written statement at the time of the incident which indicated the resident became verbally and physically upset with him when the activity program was not getting started. The AP walked the resident to her apartment while holding her hands to prevent any harm to either of them.

During an interview, the nurse stated the resident was asked about what happened during the incident and the resident knew which staff member the incident was with but was confused about what happened. A resident who witnessed the incident stated it started when the resident swung out at the AP.

During an interview with this investigator, the AP stated he was asked to cover some unlicensed caregiver duties prior to the start of his activities until a replacement arrived. While he waited for his replacement to show up and d tending to other residents, the resident became upset when activities were not started. He stated the resident became verbally confrontational, threw a package of crackers at him and swung out at him, which he caught in midair and held. The resident began to hit, bite, and scratch the AP so he walked her to her apartment. The AP stated he did not force her but held her by the arm. The AP stated he saw the thumbprint bruise on her arm the next day and admitted it probably occurred during the incident.

During interview with this investigator, the resident recalled the incident but did not know why it happened. She stated the AP grabbed her arm and "hauled" her down the hallway.

During an interview, a family member stated they became aware of the incident with the AP when, on the following day, the resident said she was afraid to go on the bus for an outing with AP aboard and observed the bruising on her arm.

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.
(c) Any sexual contact or penetration as defined in section 609.341, between a facility staff person or a person providing services in the facility and a resident, patient, or client of that facility.
(d) The act of forcing, compelling, coercing, or enticing a vulnerable adult against the vulnerable adult's will to perform services for the advantage of another.

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

Action taken by facility: The facility suspended the employee and conducted an internal investigation of the incident. The AP was given verbal coaching and retraining on handling workplace situations and returned to work at the facility.

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
	30599	A. BUILDING: _____ B. WING _____	C 02/19/2025

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 On February 19, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL305997584M /HL305993046C and HL305997324M / HL305992520C. No correction orders are issued.	0 000		