

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** HL307074682M  
**Compliance #:** HL307079627C

**Date Concluded:** October 23, 2025

## **Name, Address, and County of Licensee**

### **Investigated:**

Oak Park Place of Albert Lea  
1615 Bridge Ave  
Albert Lea, MN 56007  
Freeborn County

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

**Evaluator's Name:** Julie Serbus,  
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 perpetrators (AP#1 and AP#2) abused the resident when AP#1 was yelling at the resident and AP#2 threatened to hit the resident.

**Investigative Findings and Conclusion:** AP#1: The Minnesota Department of Health determined abuse was not substantiated. Upon viewing body camera footage provided by law enforcement, AP#1 was witnessed using a normal tone of voice stating three times that the resident was going to be transported to the hospital but was not yelling or raising her voice.

AP#2: The Minnesota Department of Health determined abuse was not substantiated. It was alleged that AP#2 threatened to hit the resident. This information was reported over a week later by an individual. There was no evidence by emergency medical services personnel onsite or other facility staff members, that AP#2 had made any threats to the resident.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement for body camera footage which was reviewed. The investigation included review of the resident record(s), facility internal investigation, facility incident reports, personnel files, staff schedules, related facility policy and procedures. Also, the investigator made a visit to the facility and observed the resident interacting with staff and other residents.

The resident resided in an assisted living memory care unit. The resident's diagnoses included depression and recent behaviors. The resident's service plan included assistance with medication administration. The resident is at risk for wandering/elopement, and falls.

The resident's abuse prevention plan indicated the resident was able to follow and understand directions, ambulates safely, a wandering risk, and requires staff to monitor for statements of wanting to leave. The resident was susceptible to abuse from other individuals and the facility was to monitor for concerns of self-abuse. The resident was alert, oriented to person, made poor decisions, has some memory loss and confusion, impulsive, and required a secured environment. Staff were to identify possible situations that may trigger aggression, including persons involved, time of day, and report any findings to nursing.

A concern arose when the resident was upset as he wanted to leave the secured memory care unit to attend a community event. The resident became verbally aggressive, was physically pounding on doors, and opened an alarmed window. Staff members intervened and attempt interventions. An additional staff member from the assisted living side of the facility entered the memory care unit to assist and was pushed by the resident. The resident continued to swear at both staff and other residents in the unit. The nurse on-call directed the staff members to call emergency medical services for transport to the emergency department.

During an interview, emergency medical personnel stated upon arrival at the facility the resident was in the living area, was agitated, and yelling. A female caregiver [name unknown but later identified as AP #1) was present and screaming at the resident. This emergency medical personnel stated she requested the female caregiver to leave the area immediately. The resident refused transportation to the emergency department, had calmed down and first responders could not forcibly transport him. The same person also stated there was a male caregiver present who was acting as a liaison to emergency medical services to provide information regarding the resident and was calmly talking to the resident.

Upon viewing body camera footage provided by law enforcement, AP#1 was witnessed using a normal tone of voice stating three times that the resident was going to be transported to the hospital but was not yelling or raising her voice.

During an interview, the guardian stated the male caregiver has been called over to the memory care unit in the past as he has a calming effect and seems to help the resident.

During an interview, the nurse stated she was contacted by management on the night of the incident. The nurse stated no reports of staff abuse directed at the resident were brought to her attention at that time. The nurse stated the report was regarding the resident's behavior and the interventions. The resident's behavior was documented in his chart as he had a history of behaviors. The nurse stated over a week after the incident had occurred, an unlicensed caregiver reported to this nurse on the night of the incident AP#2 threatened to hit the resident after the resident had pushed AP#2. The nurse stated at that point she investigated the incident more closely including conducting interviews. The nurse stated that after a more in-depth investigation due to lack of evidence it could not be determined AP#2 had made a threat to the resident.

During an interview, AP#1 stated on the night of the incident she did not witness or hear any verbal or physical threats made by AP#2. AP#1 stated she was on the phone with emergency medical services and management and could not hear all the conversations at the time.

In conclusion, the Minnesota Department of Health determined abuse was not substantiated regarding AP#1 and not substantiated regarding AP#2.

**“Not Substantiated” means:** An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment did not occur.

**Abuse: Minnesota Statutes section 626.5572, subdivision 2.**

"Abuse" means:

(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.

**Vulnerable Adult interviewed:** Yes

**Family/Responsible Party interviewed:** Yes

**Alleged Perpetrator interviewed:** Yes

**Action taken by facility:** The facility conducted an internal investigation at which time they suspended the AP#2 until the investigation was concluded.

**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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>30707</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/05/2025</b>
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NAME OF PROVIDER OR SUPPLIER  <b>OAK PARK PLACE OF ALBERT LEA</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1615 BRIDGE AVENUE ALBERT LEA, MN 56007</b>
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(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
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0 000	<p><b>Initial Comments</b></p> <p>On August 5, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL307079627C/#HL307074682M. No correction orders are issued.</p>	0 000		
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Minnesota Department of Health  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_