

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL307837942M
Compliance #: HL307838562C

Date Concluded: March 25, 2026

Name, Address, and County of Licensee

Investigated:

Cottage Grove White Pine II
6950 E Point Douglas Rd S 18
Cottage Grove, MN 55016-3000
Washington County

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

Evaluator's Name: Deb Schillinger RN BSN
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 facility abused the resident when the facility would limit repositioning or transfers to only one every two hours and did not provide the resident with three meals per day.

Investigative Findings and Conclusion: The Minnesota Department of Health determined abuse was not substantiated. The resident's concerns were addressed, and new interventions were added that better met the resident's needs. The new interventions were found to be effective.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident record, hospital records, facility internal investigation, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed resident and staff interactions during an onsite visit.

The resident resided in an assisted living secured memory care unit. The resident's diagnoses included Parkinson's disease, dementia, and recent diagnosis of colon cancer. The resident's service plan included assistance with medication management, transfers using a mechanical lift, every two-hour repositioning, and toileting. The resident's assessment indicated the resident was cognitively impaired, unable to make her own decisions and required the assistance of two caregivers with mechanical lift for transfers and mobility. The resident was also receiving hospice services for a terminal illness.

A concern arose the resident was not being repositioned enough, was not provided with three meals per day and a termination notice was given to the resident.

A facility document indicated a meeting was held to determine if the facility was able to meet the resident's needs with ombudsmen, hospice, family and facility staff. New interventions were added to the resident's plan of care to address pain, a posted schedule to address transferring times, and staff reeducation. A follow-up meeting attended by the same attendees was held after 30 days and found the new interventions to be effective. The resident's needs were better met with the posted schedule, pain management, and re-trained facility caregivers.

During an interview, a manager reported concerns were brought to her attention the resident was exceeding the care determined by the facilities Uniform Disclosure of Assisted Living Services and Amenities (UDLASA). A collaborative meeting was held with providers and new interventions were added to better meet the resident's needs. Videos were provided that indicated discourteous care by two caregivers, one was re-educated, and the other's employment was terminated. All caregivers received training and instructions to better meet the resident's needs. The manager reported the interventions were effective and no additional concerns were identified.

In conclusion, the Minnesota Department of Health determined abuse 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.

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: No, due to cognitive impairment

Family/Responsible Party interviewed: Yes

Alleged Perpetrator interviewed: Not Applicable

Action taken by facility: Care conference was held where new interventions were added to better meet the resident's needs, caregivers were re-educated and situation improved with updated service plan.

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: 30783	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/07/2026
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NAME OF PROVIDER OR SUPPLIER COTTAGE GROVE WHITE PINE II	STREET ADDRESS, CITY, STATE, ZIP CODE 6950 EAST POINT DOUGLAS ROAD S COTTAGE GROVE, MN 55016
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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
0 000	<p>Initial Comments</p> <p>On January 7, 2026, the Minnesota Department of Health initiated an investigation of complaint #HL307838562C/#HL307837942M.</p> <p>No correction orders are issued.</p>	0 000		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____