Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL357502120M
Compliance #: HL357507867C

Date Concluded: May 7, 2026

Name, Address, and County of Licensee Investigated:
Whitefish at the Lakes Senior Living
35625 Ostlund Ave.
Crosslake, MN 56442
Crow Wing County

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

Evaluator's Name:
Jana Wegener, 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): Two residents (Resident #1 and Resident #2) were neglected when the facility failed to provide supervision resulting in physical altercations between resident #1 and resident #2.

Investigative Findings and Conclusion: The Minnesota Department of Health determined neglect was not substantiated. Although there were instances when resident #1 and resident #2 had altercations, the facility took appropriate steps to address these times and to reduce the risk of recurrence.

Resident records reviewed, and staff interviewed indicated the residents plan of care and individualized abuse prevention plans were followed at the time of the incidents. Caregivers responded to the resident-to-resident altercations promptly, separated the residents involved to ensure safety, called 911, assessed the residents for injuries, and implemented interventions to help prevent recurrence.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement and the resident's family members. The investigation included review of the resident record(s), facility internal investigations, facility incident reports, facility schedules, law enforcement reports, and related facility policy and procedures Also, the investigator observed resident and staff interactions at the facility.

A concern arose when two cognitively impaired residents who resided in a secure memory care unit engaged in an unwitnessed physical altercation.

Resident #1

Resident #1 resided in an assisted living facility memory care unit with diagnoses including anxiety disorder, cognitive impairment of unknown etiology, and moderate dementia with other behavioral disturbance.

Resident #1's individual abuse prevention plan (IAPP) identified Resident #1 had moderate cognitive impairment and was at risk of being abused as well as at risk of abusing others. The IAPP identified Resident #1 had attention seeking "button pushing" behaviors and could be physically/verbally aggressive and had a tendency of inappropriately touching others. The IAPP included an extensive list of various interventions for caregivers to help manage Resident #1's behaviors.

An incident report one evening at 6:42 p.m. indicated Resident #1 was involved in a physical altercation with Resident #2 in a common area. The report indicated 911 was called, and caregiver (s)reported the incident to nursing immediately. The report indicated the nurse assessed Resident #1 following the incident and noted redness on Resident #1's upper abdomen, chest, and leg. Resident #1's family and provider were notified. The report indicated the following day Resident #1 was again assessed and at that time several bruises were noted on the resident's chest, upper abdomen, and thigh, but the resident did not require medical attention.

Resident #1's Medication Administration Record (MAR) at the time of the incident included orders for Eliquis (a blood thinner that can cause an individual to bruise or bleed more easily).

Resident #1's care plan indicated every 30-minute safety checks were added following the first incident to help prevent recurrence. In addition, a one-on-one homecare agency staff was implemented to help redirect Resident #1's behaviors 7 days per week from 7:00 a.m. to 7:00 p.m. A facility communication indicated Resident #1's one-on-one homecare agency staff was not available the day incident #2 occurred.

42 days after the initial incident, another report indicated at 6:15 p.m. indicated Resident #1 and Resident #2 had another physical altercation in a common area. The report indicated Resident #1 was assessed for injuries, but none were noted. While there were no apparent

witnesses to the event, the facility reviewed video surveillance as part of its internal investigation. The report indicated when leadership reviewed video surveillance the residents had “triggered one another” and hit each other. The report indicated both residents plan of care were followed, at the time however both residents’ plan of care were updated to keep the two residents separated.

Resident #1’s service delivery record indicated the resident’s plan of care including safety checks were provided at the time the incidents occurred.

Resident #1’s progress notes during the time of the incidents included daily documentation of Resident #1’s behaviors which included verbal outbursts and physically aggressive conduct toward other residents, staff, and family members including putting his hands around a caregiver’s neck, grabbing wrists, hitting, kicking, yelling, making sexual comments, and inappropriately touching others private parts. The documentation showed caregivers ongoing efforts to try to manage, distract, and redirect Resident #1’s behaviors to ensure Resident #1 and other residents were safe using various interventions from the residents IAPP and plan of care.

During an onsite observation, the investigator observed caregiver implementing Residents #1’s IAPP including providing supervision, redirection, and guidance in response to Resident #1’s behaviors to ensure residents were safe. Resident #1 was observed enter the common space dining room where several residents were having breakfast and sat across from one female resident near the window. Resident #1 was observed to suddenly get up from his chair and briskly walk across the dining room towards Resident #2, caregiver(s) immediately responded and stood beside the residents. Resident #1 picked up Resident #2’s coffee cup and loudly and repeatedly banged it on the table in front of Resident #2’s face. Resident #2 remained seated and did not respond to Resident #1’s behavior. Another caregiver approached Resident #1 and redirected him to go for a walk. Resident #1 responded to the intervention, let go of the cup, and walked beside the caregiver down the hallway. Resident #1 then went toward another resident’s closed door, read the resident’s name aloud, then grabbed and shook the door handle forcefully trying to enter. The caregiver calmly and softly responded, “This resident is not feeling well, she is going to rest”, to which Resident #1 responded “the rest of what?”, then resumed following caregiver down the hall to another common area at the end of the hall where they played a game of cards.

During an interview, Resident #1 denied any issues with other residents in the secure memory care unit.

Resident #2

Resident #2 resided in an assisted living facility memory care unit with diagnoses including anxiety, depression, aphasia (difficulty finding words), and dementia without behavioral disturbance.

Resident #2's individual abuse prevention plan (IAPP) identified Resident #2 had moderate cognitive impairment and was at risk of being abused as well as at risk of abusing others. The IAPP directed caregivers to keep Resident #2 away from residents who have triggering behaviors for Resident #2 including poking, unwanted touching of other residents, and loud vocalizations or sounds.

Resident #2's progress note following the first incident indicated Resident #2 reported to law enforcement Resident #1 had repeatedly kicked and poked him and he got "fed up" and "pinned" Resident #1 down. Resident #2's progress notes from the time of the second incident indicated Resident #2 was triggered by another male resident on unit who began to yell. Resident #2 was removed from the area to allow time for the other male resident to deescalate.

Resident #2's incident report for the second incident indicated Resident #2 reported Resident #1 was groping a female resident and something had to be done. Resident #2 was assessed for injuries and had sustained a cut to his eye temple area and a bruise on his left forearm from the altercation with Resident #1.

Resident #2's MAR included orders for Aspirin at the time the incident occurred which could increase the resident's risk of bruising or bleeding.

When interviewed Resident #2 stated he felt like caregivers were doing everything they could and indicated he felt safe in the facility and well cared for.

Facility video surveillance from the time of the incidents was requested but was not available for review.

When interviewed, caregivers working on the memory care unit when each incident occurred stated they were assisting other residents who required 2 caregivers assistance when Resident #1 and Resident #2 had their physical altercations. The caregiver stated they had checked on both residents within minutes prior to the altercations occurring and they had no indication of any concerns before they went to assist the other residents.

When interviewed several caregivers verbalized knowledge of both resident's plan of care and discussed various interventions they utilized and what they would do if attempts to redirect behaviors were not effective including removing other residents to a safe location, and/or calling 911 if needed to ensure resident safety.

When interviewed facility leadership stated after each incident they reviewed possible causes for each incident, added safety checks, hall monitoring, and changed the environment seating to create separate spaces to help reduce triggering behaviors.

When interviewed Resident #2's family member stated he felt like caregivers were attentive to the resident's needs and doing their best to handle a challenging situation.

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 Adult interviewed: Yes
Family/Responsible Party interviewed: Yes, Resident #1’s family did not respond to interview attempts.
Alleged Perpetrator interviewed: N/A

Action taken by facility: Facility caregivers responded to the incidents, separated the residents, called 911, and reported the incident. The residents were assessed for injuries and took steps to reduce the risk in the future for both residents.

Action taken by the Minnesota Department of Health: No action was 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
	35750	A. BUILDING: _____ B. WING _____	C 04/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITEFISH AT THE LAKES SENIOR LIVING	35625 OSTLUND AVENUE CROSS LAKE, MN 56442

(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 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: #HL357502841M/#HL357501175C, and #HL357502120M/#HL357507867C On April 21, 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 85 residents receiving services under the provider's Assisted Living with Dementia Care license. No correction orders were issued for #HL357502120M/#HL357507867C nor #HL357502841M/#HL357501175C.	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.	