Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL357502841M
Compliance #: HL357501175C

Date Concluded: May 7, 2025

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: 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(s): The facility neglected Resident #1 and Resident #2 when Resident #1 touched Resident #2's genitals as indicated by video surveillance.

Investigative Findings and Conclusion: The Minnesota Department of Health determined neglect was inconclusive. While it was true Resident #1 had document instances of sexually inappropriate interactions towards other residents, the investigation did not identify an instance(s) consistent with the allegation.

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

A concern arose when it was reported Resident #1 touched Resident #2 in the genital area while in Resident #2's bedroom for which there was video evidence.

Resident #1

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

Resident #1's individual abuse prevention plan (IAPP) identified Resident #1 was at risk for being abused as well as at risk for abusing others. The IAPP identified Resident #1 had attention seeking behaviors with a tendency of inappropriately touching others. The IAPP had an extensive list of various interventions for staff to help manage Resident #1's behaviors.

Resident #1's progress notes reviewed during the time of the allegation included 15 instances with documentation of Resident #1 making sexually inappropriate comments/statements and grabbing, touching, flicking, or poking resident's and staff's private parts including breasts, buttocks, and penis. The progress notes had no documentation of an incident matching the description in the MAARC report.

Resident #2

Resident #2 resided in an assisted living facility memory care unit with diagnoses including frontal lobe dementia of unspecified severity with mood disturbance, and executive function deficit.

Resident #2's IAPP identified he was at risk for abuse and unable to report concerns of abuse due to cognitive and communication impairment. The IAPP indicated the resident was at risk of being touched inappropriately by other vulnerable adults, and indicated staff were trained to recognize and report suspected instances of abuse and neglect.

Resident #2's medical record was reviewed, however no instance similar to the allegation was identified. One progress note described an instance where Resident #1 and Resident #2 were in a common area living room watching a movie when Resident #1 patted Resident #2 on the leg and said "hi". The note indicated a few moments later Resident #1 flicked Resident #2 in the penis area which caused Resident #2 to appear uncomfortable in his seat and crossed his legs. The note indicated staff were able to redirect Resident #1 with no further issues noted.

Incident reports involving Resident #1 and Resident #2 were requested, however none of those provided matched the scenario described in the allegation. -

The investigator contacted law enforcement and requested police reports involving Resident #1 and Resident #2, however none were available.

During an interview, the facility leadership stated they had not been made aware of any concerns involving Resident #1 touching Resident #2's genitals in his bedroom or observing the incident on video surveillance. Facility leadership stated the video surveillance does not show the entrance to nor the interior of Resident #2's room.

When interviewed several staff stated Resident #1 had impulsive attention seeking behaviors including inappropriate touching of residents and staff's private parts. Staff indicated they attempted to redirect Resident #1 but attempts to redirect were not always effective, so they ensured safety of other residents by removing them from the area to a safe location if needed. During interviews, the staff members denied any knowledge of any occurrence as described in the allegation.

When interviewed Resident #2's family member stated staff members were very on top of responding to Resident #1's behaviors and ensuring Resident #2 and other residents were safe. The family member stated she was made aware of a concern where Resident #1 briefly touched Resident #3's genital area in a public space, and staff immediately redirected Resident #1. The family member stated Resident #2 had no distress or behavioral changes following the incident of touching. The family member stated staff had taken appropriate steps to ensure residents who live there were safe and cared for.

During the onsite observation, the investigator observed staff implementing Residents #1's IAPP including providing supervision, redirection, and guidance in response to Resident #1's behaviors to ensure residents were safe.

In conclusion, the Minnesota Department of Health determined neglect 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.

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, attempted not interviewable.
Family/Responsible Party interviewed: The attempts to interview a family member of Resident #1 were unsuccessful. A member of Resident #2's family was interviewed.

Alleged Perpetrator interviewed: Not applicable.

Action taken by facility: None.

Action taken by the Minnesota Department of Health: No further 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
	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.	