Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL357503527M
Compliance #: HL357502919C

Date Concluded: August 24, 2026

Name, Address, and County of Licensee Investigated:
Whitefish at the Lakes
35625 Ostlund Avenue
Crosslake, MN 56422
Crow Wing County

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

Evaluator's Name:
Katherine Barnhardt 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):
The alleged perpetrator (AP), a facility staff member, abused the resident when the AP restrained the resident and the AP had the resident arrested.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was not substantiated. The AP followed interventions and placed herself between two residents to prevent an altercation. A verbal exchange began between the resident and another resident when he sat uninvited at a table. Unlicensed staff cleaning up the dining area were unable to redirect the resident and the AP was summoned to the memory care unit. The AP intervened, turned the resident's dining room chair forty-five degrees away from the second resident to de-escalate and prevent a physical altercation. When the AP stepped between the residents and turned the chair, the resident grabbed the groin region of the AP. The resident's hand was moved away by the AP without restraint or injury to the resident. The resident was unable to be redirected, and law enforcement was called. Law enforcement removed the resident from the memory care unit

with medications for the resident that facility staff signed out. The facility received a correction order for failing to coordinate a move for the resident.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, unlicensed staff and the AP. The investigator contacted law enforcement, case managers and social workers. The investigation included review of the resident record(s), hospital records, pharmacy records, internal facility investigation, facility incident reports, personnel files, staff training records, staff schedules, law enforcement reports, jail records, facility video footage, body camera footage, related facility policy and procedures. Also, the investigator observed facility staff provide direct care to residents.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia and congestive heart failure. The resident's service plan included assistance with medication management, meal reminders and behavioral management. The resident's assessment indicated the resident was independent with ambulation, most activities of daily living and could communicate needs. The resident's assessment indicated the resident wandered throughout the memory care unit, required frequent staff intervention, redirection, and monitoring for aggression and inappropriate touch to other residents and staff.

The resident's record indicated the resident attempted to provoke other residents and inappropriately touched staff. The resident's record indicated a detailed history of the resident's preferences and more than two dozen interventions that staff could use as interventions and distractions. The facility requested one-to-one staffing, alternative placement, medication reviews, a short-term psychiatric stay and termination of contract when interventions were ineffective. Updates were provided to a medical provider weekly and facility licensed staff requested more recommendations.

Facility records indicated on the day of the incident unlicensed staff attempted to intervene between the resident and a second resident seated at a dining room table when a confrontation between the residents occurred. The resident had completed his meal in a separate area from the main dining room and walked up to a dining area where another resident was still eating. The resident walked up to the other resident's table, sat down and took a cup and fork away from another resident. Unlicensed staff were cleaning the dining area, observed the resident initiated a verbal exchange with another resident and unlicensed staff intervened. Unlicensed staff phoned the AP for assistance when the resident was unable to be redirected and behaviors escalated. The AP applied one of the recommended interventions and placed herself between the two residents. The AP turned the resident's chair at a forty-five-degree angle away from the other resident for de-escalation. When the AP intervened, the resident grabbed the AP's groin region, and the AP used an open hand method to remove the resident's hand without injury to the resident. Facility records indicated the AP called law enforcement for assistance.

Law enforcement reports indicated law enforcement was called multiple times for assistance to manage the resident's behaviors. A law enforcement report indicated the AP requested assistance and reported the resident grabbed the AP's groin region when the AP intervened to prevent an altercation between two residents. A law enforcement report indicated the AP demonstrated to an officer where the AP placed her foot behind the leg of a chair to prevent the resident from engaging the other resident. The AP requested assault charges and law enforcement initiated an arrest of the resident. A law enforcement report indicated medications were requested, signed out and sent with law enforcement for the resident. Law enforcement transported the resident to an emergency room.

Facility video that was five minutes and 49 seconds in length, showed at approximately 0:13 seconds the resident seated at a dining room table with two other residents and talking to one of the residents with a fork in his hand. The AP entered the video from the left at approximately 0:26 seconds as an unlicensed staff attempted to remove the fork from the residents left hand unsuccessfully and the resident began banging the fork on the table. At approximately 0:34 seconds the AP took the fork away from the resident, turned the chair sideways to the table, handed the fork to an unlicensed staff and motioned for the resident to depart. The AP was observed talking with the resident and standing to the resident's left. At approximately one minute and 10 seconds the AP further angled the chair away from the other residents at the table and the AP stood between two seated male residents. The AP talked with the resident and at approximately one minute and 35 seconds an unlicensed staff approached and stood to the right of the resident with the AP to the left. At approximately two minutes and 14 seconds the AP and the unlicensed staff used the chairs armrests to pull the chair forward and block the residents view of the other resident at the table and at approximately two minutes and 43 seconds the AP placed her left foot behind the left chair leg. At approximately three minutes and 41 seconds the resident leaned down and to the left and the AP moved to the right. Approximately five seconds later the AP was observed jumping slightly back and moving the resident's left arm away from her. At approximately three minutes and 50 seconds the AP was observed to the right of the resident, and a close interaction occurred between the resident and the AP, however arm movements were not visible on camera. At approximately four minutes and 14 seconds the resident used his feet to push the chair backward against a wall and talked with the AP. At approximately five minutes and 49 seconds the AP was observed exiting the video with a cell phone to her ear. The resident was free to stand from the chair and walk away throughout the observed video.

During an interview, unlicensed staff stated the resident was independent with ambulation, and the resident inappropriately touched a lot of the facility's female staff. Unlicensed staff had been taught how to remove the resident's hands in a safe manner that would not injure the resident. Unlicensed staff stated there were many interventions for the resident and at times facility staff had to place themselves between the resident and others to prevent or de-escalate altercations. An unlicensed staff stated the day of the incident she called for the AP's assistance when the resident threatened another resident with a fork, and she feared it would get

physical. The AP turned the chair the resident was sitting on and stepped between the residents to de-escalate. Unlicensed staff stated she was unsure of what happened between the resident and the AP however, had heard the resident grabbed her between the legs and she was unsure why law enforcement was called because “that was our normal.” The resident inappropriately touched staff and made comments often. Unlicensed staff stated licensed staff had not been grabbed like that before. Unlicensed staff stated she did not think the AP restrained the resident in a chair because the resident was free to walk away at any time.

During an interview, licensed staff stated the usual admission process had not been followed and the facility recognized right away the resident required a memory care unit for safety reasons. Licensed staff stated behaviors escalated quickly and the resident was “very handsy” and aggressive with co-residents and staff. Licensed staff stated the resident threatened another resident with a fork and the AP was called to assist. The AP put herself between the residents to get the residents’ attention and the resident grabbed the AP between the legs. Licensed staff stated staff were directed to call 911 if they felt unsafe.

During an interview, facility leadership stated as time went on the resident’s behaviors escalated and pages of interventions were tried. Facility leadership stated multiple incidents of sexual inappropriateness toward female staff and visitors had occurred and the facility requested interventions that were denied. Facility leadership stated the resident attempted to initiate an altercation with another resident and facility staff were unable to redirect the resident. Unlicensed staff called the AP to assist, and the resident grabbed the AP’s groin region. Facility leadership stated facility staff were directed to call 911 if they feared for their safety.

During an interview, a case manager stated she assisted the family with alternative placement and oversight of the resident’s needs. A dementia specialist was contacted to assist and make recommendations for the facility to manage the resident’s behaviors and many medical providers collaborated. The facility hadn’t implemented the recommendations and when something happened in the memory care unit the AP was called up to take care of it because the AP had extra training in dementia. A case manager stated the facility’s documented information about the resident was not factual or up to date and facility staff spoke of the resident as if he did not have dementia.

During an interview, the AP stated she had years of experience with behavioral health and long-term care. The resident had sexually inappropriate behaviors and dozens of interventions. Requests for more interventions, medications and a short-term psychiatric stay were denied. The AP stated the day of the incident the AP’s assistance was requested by unlicensed staff and when she arrived in the memory care unit the resident was hollering back and forth with another resident and pounding on the table of the other resident. The AP stated she turned the resident’s dining room chair sideways to the table to prevent the resident from re-engaging the other resident and stepped between the residents. The AP and another staff pulled the chair

forward approximately 6” to prevent the resident from antagonizing the other resident. The resident kept using his feet to push his chair backwards to have access to the other resident and the AP placed a foot behind a chair leg to prevent the chair from going backwards. The AP told the resident she had not touched him when he stated she was hurting him, and the resident started to touch each of the AP’s knees asking if it hurt. The resident then grabbed the AP’s groin region. The AP stated she removed his hand and instructed the resident “do not touch me there”. The AP stated the resident could not be redirected, and law enforcement was called. The AP stated the resident had not been restrained, and the resident was free to stand and walk away at any time.

During an interview, a family member stated the resident’s dementia diagnosis was shared with facility leadership during the admission process, however, did not think paperwork from the previous facility was provided to the current facility. A family member stated family and facility leadership stayed in constant communication and the family offered to assist in any way to keep the resident at the facility. A family member stated facility leadership reported the resident was inappropriately touching female staff in the facility and interventions were ineffective. A family member stated family reached out to the facility several times during the incident and spoke with two different staff that did not inform the family the resident had been removed from the facility.

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, unavailable
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The facility implemented interventions and collaborated with outside agencies to address the resident's needs.

Action taken by the Minnesota Department of Health:

The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

You may also call 651-201-4200 to receive a copy via mail or email

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 07/27/2026

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 ******ATTENTION****** 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: #HL357503527M/#HL357502919C On July 27, 2026, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction order is issued. At the time of the complaint investigation, there were 86 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL357503527M/#HL357502919C, tag identification 1110.	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.	
01110 SS=D	144G.55 Subdivision 1 Duties of facility (a) If a facility terminates an assisted living	01110		

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01110	Continued From page 1 contract, reduces services to the extent that a resident needs to move or obtain a new service provider or the facility has its license restricted under section 144G.20, or the facility conducts a planned closure under section 144G.57, the facility: (1) must ensure, subject to paragraph (c), a coordinated move to a safe location that is appropriate for the resident and that is identified by the facility prior to any hearing under section 144G.54 and document the same; (2) must ensure a coordinated move of the resident to an appropriate service provider identified by the facility prior to any hearing under section 144G.54, provided services are still needed and desired by the resident; and (3) must consult and cooperate with the resident, legal representative, designated representative, case manager for a resident who receives home and community-based waiver services under chapter 256S and section 256B.49, relevant health professionals, and any other persons of the resident's choosing to make arrangements to move the resident, including consideration of the resident's goals and document the same. (b) A facility may satisfy the requirements of paragraph (a), clauses (1) and (2), by moving the resident to a different location within the same facility, if appropriate for the resident. (c) A resident may decline to move to the location the facility identifies or to accept services from a service provider the facility identifies and may choose instead to move to a location of the resident's choosing or receive services from a service provider of the resident's choosing within the timeline prescribed in the termination notice. This MN Requirement is not met as evidenced by:	01110		

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01110	Continued From page 2 Based on record review and interview, the licensee failed to ensure a coordinated move during a facility initiated discharge for one of one residents (R1) reviewed. R1 was relocated to an emergency room and representatives had not been notified even though representatives had phoned the facility and spoke with two facility staff. The facility declined to accept the resident back causing R1 to be housed at a jail facility, and an emergency room. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included dementia. R1's unsigned service plan dated April 27, 2026, indicated R1 received medication management, behavior management, housekeeping and laundry services. R1's assessment indicated R1 required redirection to address aggression, provoking and inappropriate touching of co-residents and facility staff. R1's record indicated an initial termination of contract was issued on February 24, 2026, and appealed by R1. R1's record indicated on June 11, 2026, a final determination was issued to terminate R1's assisted living contract with the facility.	01110		

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01110	Continued From page 3 R1's progress notes dated May 9, 2026, indicated an incident occurred at the facility and R1 was removed by law enforcement. Law enforcement records signed and dated on May 19, 2026, by social worker (SW)-B indicated registered nurse (RN)-D declined to allow R1 to return to the facility when requested by SW-B. A Discharged Resident Roster, dated July 27, 2026, indicated R1's services started May 31, 2025, and ended when R1 was discharged June 30, 2026. During an interview on July 27, 2026, at 1:30 p.m., SW-B stated when the request was made to RN-D for R1 to return to the facility it was a "hard and drawn line" R1 would not be allowed to return. During an interview on July 29, 2026, at 3:01 p.m., director of nursing (DON)-E stated the facility had received a call from SW-B, however could not recall if SW-B requested the facility allow R1 to return. During an interview on August 3, 2026, at 1:03 p.m., licensed assisted living director (LALD)-C stated R1 was removed from the facility on May 9, 2026, as the result of an incident that occurred at the facility. LALD-C stated R1's contract termination was started January 14, 2026, and finalized June 11, 2026. LALD-C stated R1 was not allowed to return to the facility after the removal on May 9, 2026. A policy titled Contract Termination, revised November 2025, indicated [name of facility] would follow the proper procedures for terminating an Assisted Living Contract with a	01110		

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01110	Continued From page 4 resident. Time Period to Correct: Seven (7) Days	01110		