Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL242531645M
Compliance #: HL242532750C

Date Concluded: May 12, 2025

Name, Address, and County of Licensee Investigated:
Whispering Pine Assisted Living
701 Polk Street
Anoka, MN 55303
Anoka County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Lori Pokela R.N.
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 alleged perpetrator, (AP), abused the resident, when, after entering the resident's room without permission and the resident became physically aggressive, the AP grabbed the resident's hands behind his back and restrained him on his bed until law enforcement arrived.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was inconclusive. Due to conflicting information provided, it was unable to be determined if abuse occurred. Additionally, the resident declined to provide additional details of the incident.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's case worker. The investigation included review of the resident record(s), hospital records, facility incident reports, personnel files, staff schedules, law enforcement report, and related facility policy and

procedures. Also, the investigator observed the facility's physical environment, cares provided by staff, and staff interactions which included the AP's interactions with other residents.

The resident resided in an assisted living facility. The resident's diagnoses included borderline personality disorder and traumatic brain disorder (TBI). The resident had a history of substance abuse, suicide attempts, and assaults. The resident's service plan included assistance with medication management, laundry, and housekeeping. The resident's assessment indicated the resident was oriented to person, place, and time, and had a history of behaviors such as agitation, aggression, and anxiety. Additionally, the resident's assessment indicated staff were to provide hourly safety checks and pain interventions such as redirection, a calm environment and as needed (PRN) medications.

The resident's facility medical records indicated the resident returned to the facility three-days prior to the incident from a hospital stay where the resident was treated for severe back pain and suicidal ideations.

Documentation indicated the resident did not eat his morning meal, did not come out of his room, and was not taking his prescribed medications the morning of the incident. The AP knocked on the resident's door several times before the resident opened his door. When the door was opened, the resident hit, kicked, and attempted to choke the AP. The AP was able to release the resident's hold, grab the resident's hands and restrain the resident on the bed while another staff member contacted 911. The report indicated the AP sustained an abrasion on the back of the neck. The resident complained of back pain and had an injured toenail. When emergency personnel arrived, the resident was transported to the hospital for evaluation.

A law enforcement report indicated the resident's right big toenail was ripped off, the right toenail bed was bleeding, scratches were visible to the back of his neck, he had a bloody lip and complained of back pain. The AP also had noted scratch on the back of the neck.

The resident's hospital emergency department records indicated the resident arrived at the hospital with agitation, an injured right great toenail bed, a toenail bent back, complaints of back pain and a scrape to the chin. A CT scan (a non-invasive imaging technique that uses X-rays to create detailed cross-sectional images of the body) revealed the resident had no fractures but early stages of degeneration in his back. The resident was admitted to the hospital's psychiatric unit for a mental health evaluation.

While in the hospital, the resident reported conflicting accounts of the incident to several staff members.

During an interview, the resident stated he was having difficulty sleeping the night before the incident and was sleeping when the AP started pounding on his door, threatening to call law enforcement if he did not open it. The resident stated after he opened the door, the AP barged into the resident's room and wanted to look through his personal items. The resident declined

to provide details about how the AP got into his room or the details of the physical altercation, but stated his shoulder still hurt from the incident.

During an interview, the AP stated facility staff reported concerns because the resident did not eat his meal, refused to take his prescribed medications or come out of his room. The AP stated he knocked on the resident's door, the resident opened the door after a couple of minutes, the AP stepped into the resident's room. The AP stated he did not hear the resident say he could not enter the room, so he informed the resident a safety check was being conducted, when the resident hit, kicked, and reached for the AP's neck. The AP stated he struggled to release the resident's hold and when the resident dropped to his bed where the AP caught hold of both the resident's hands behind the resident's back, yelled for staff to call 911 and awaited law enforcement's arrival.

During an interview, the resident's responsible party stated the incident was reported and they were made aware of an injury to the resident's toenail and some injuries to the AP. The resident's responsible party could not recall any other injuries sustained in the incident.

In conclusion, the Minnesota Department of Health determined abuse 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.

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: Yes
Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The facility completed an incident report, contacted 911, and the resident was transported to the hospital.

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
	24253	A. BUILDING: _____ B. WING _____	C 04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CEDARS	701 POLK STREET ANOKA, MN 55303

(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.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: #HL242532750C/#HL242531645M On April 22, 2025 through April 30, 2025, 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 four residents receiving services under the provider's Assisted Living license. The following correction orders are issued for #HL242532750C/#HL242531645M, tag identification 0590	0 000		
0 590 SS=D	144G.42 Subd. 3 Facility restrictions (a) This subdivision does not apply to licensees that are Minnesota counties or other units of government. (b) A facility or staff person may not: (1) accept a power-of-attorney from residents for	0 590		

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0 590	Continued From page 1 any purpose, and may not accept appointments as guardians or conservators of residents; or (2) borrow a resident's funds or personal or real property, nor in any way convert a resident's property to the possession of the facility or staff person. (c) A facility may not serve as a resident's legal, designated, or other representative. (d) Nothing in this subdivision precludes a facility or staff person from accepting gifts of minimal value or precludes acceptance of donations or bequests made to a facility that are exempt from section 501(c)(3) of the Internal Revenue Code. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure licensure requirements were followed when the licensee allowed a staff member, the licensee's former vice president, current administrative personnel, (ADM)-B, to serve as guardian for one of four residents (R1) who resided at the facility. 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 borderline personality disorder, traumatic brain injury, (TBI) and a history of suicide and lumbosacral strain.	0 590	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.	

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0 590	Continued From page 2 R1's licensee profile sheet indicated an employee of licensee's corporate office (ADM)-B was listed as R1's guardian. R1's service plan dated August 17, 2024, indicated R1 received services for medication management, housekeeping, laundry and meal preparation. The service plan was signed by ADM-B, as R1's responsible person. R1's assisted living licensee agreement, uniform disclosure of services, and R1's assisted living bill of rights dated August 17, 2023 , was also signed by ADM-B, as R1's legal representative. R1's progress notes dated November 20, 2024, completed by licensed practical nurse, (LPN)-E, indicated ADM-B and R1 met R1's new case manager. R1's progress notes dated December 23, 2024, completed by registered nurse, (RN)-C, indicated R1 slipped on ice while out for a walk. R1 complained of upper back pain and had some abrasions on his left arm. The note indicated R1's guardian, ADM-B, was notified of the incident. A Guardian and Conservator Registry dated March 4, 2025, indicated ADM-B was the appointed guardian for R1. R1's change in condition nursing assessment dated March 28, 2025, indicated R1 was alert and oriented to person, place, time, and situation. The assessment indicated ADM-B was R1's decision making authority and guardian. R1's progress notes dated March 31, 2025, completed by registered nurse clinical nursing services (RN)-G, indicated R1's guardian ADM-B	0 590	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.	

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0 590	Continued From page 3 was notified of an incident and R1's transport to the hospital. R1's hospital records dated March 31, 2025, at 11:09 p.m. indicated ADM-B was R1's legal guardian. R1's progress notes dated April 2, 2025 indicated an emergency room, (ER) letter was sent to R1's guardian, ADM-B via email. Upon entering the licensee on April 22, 2025, at 10:39 a.m., unlicensed personnel, (ULP)-L called ADM-B, to inform her of the Minnesota Department of Health (MDH) investigator's arrival. ADM-B requested to speak with the MDH investigator and proceeded to introduce herself over the phone as the licensee's administrative staff. A business card provided by RN-G, sent to the MDH investigator via email on April 22, 2025 at 2:18 p.m., contained ADM-B's business card that identified ADM-B as the licensee's vice president and housing manager. On April 24, 2025, at 12:48 p.m., a Net study 2.0 Roster indicated ADM-B to have an official background study and be an eligible employee in a managerial position with the licensee. During an interview dated April 22, 2025, at 1:00 p.m., RN-G stated ADM-B's title at the time of the investigation was corporate vice president of the licensee. During an interview dated April 25, 2025, at 12:02 p.m., the former licensed assisted living director, (LALD)-A, stated having concerns with the conflict of ADM-B having guardianship over the	0 590		

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0 590	Continued From page 4 resident and working in a vice president-type capacity for the licensee's corporate offices and serving as a legal guardian for R1. During an interview dated April 25, 2025, at 2:06 p.m., R1 stated ADM-B was his legal guardian for approximately three to four years. During an interview dated April 28, 2025, at 10:02 a.m., ADM-B stated her position at the licensee's corporate offices was an administrative personnel. ADM-B also stated she had been R1's guardian for approximately five years. The licensee's Restrictions policy, dated June 2, 2022, revised August 28, 2023, indicated" neither WPAL [Whispering Pines Assisted Living] or any of it staff may accept a power-of-attorney from residents for any purpose, accept RN-G appointments as guardians or conservators of residents, borrow funds from a resident, or borrow personal or real property from a resident. " The licensee provided Minnesota Assisted Living Bill of Rights dated May 16, 2021, indicated ADM-B as the person to whom licensee/resident problems may be directed, with the licensee's corporate address indicated. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) Days	0 590		