*Protecting, Maintaining and Improving the Health of All Minnesotans*

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** HL305997584M
**Compliance #:** HL305993046C

**Date Concluded:** March 10, 2025

**Name, Address, and County of Licensee Investigated:**
Whispering Oak Place
903 Calverly Court
Ellendale, MN 56026
Steele County

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

**Evaluator's Name:** Christine Bluhm, 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:** The alleged perpetrator (AP) abused the resident when the AP placed his hand under the resident's shirt and on her chest after she asked the AP to check her heart rate. The AP also touched her thigh and groin area later the same night.

**Investigative Findings and Conclusion:** The Minnesota Department of Health determined abuse was inconclusive. The AP, who was an unlicensed caregiver, and the resident had different accounts of their interactions that night and there were no witnesses to the incident.

The investigator conducted interviews with facility staff members, including administrative staff and unlicensed staff. The investigator contacted law enforcement and case workers. The investigation included review of the resident record, facility internal investigation, facility incident reports, personnel files, staff schedules, and related facility policy and procedures.

The resident resided in an assisted living facility. The resident's diagnoses included heart failure and diabetes. The resident's service plan included assistance with insulin and blood sugar

management, medications and stand-by bathing assistance. The resident's assessment indicated she was oriented, independent with decision-making and able to make her needs known.

A concern arose when it was reported the AP responded to a request to check the resident's pulse as she felt it was low. While she offered her wrist for palpation, the AP checked her pulse on her chest claiming that was better. It was also reported the AP touched the resident's legs and groin later that same night. The concern was reported about two days after it was alleged to have occurred [the alleged event occurred Wednesday and was reported Friday].

The resident's progress notes indicated the resident provided an account of the incident and stated the AP came into her room and put his hand under her shirt and groped her legs and groin. When the resident was asked if she needed to talk about the incident, the resident stated that she did not remember whether she took her medication or not that night and did not know if she was dreaming or if it really happened. The same document indicated the resident was told the incident was being investigated.

The facility provided an email from the AP dated the same day the event was reported, Friday, which indicated he did enter the resident's room to administer her medications that evening but denied touching or fondling the resident.

A review of the electronic medication record indicated the AP did document giving the resident her medications the previous Wednesday evening.

The following Monday the resident's progress notes indicated the resident was asked to write a description for what occurred. The resident wrote a note stating the event occurred as the caregiver wrote it down, but did not provide further description.

Also on that Monday, a police report indicated the facility contacted law enforcement. The police report indicated the resident reported she requested a pulse check and offered her wrist, but the AP said he had a "better way", put his hand under her shirt, and touched her breast over her bra. Later, the same evening he returned to check on her, put his hand down her pants, and rubbed her thigh and her vagina over her underwear. About a month later, the police were advised by the facility she may have been dreaming about the sexual assault and so the police re-interviewed the resident again. During that interview, the resident related the same events and denied it was a dream although she described is as a "nightmare". The same document indicated the resident said no one was else was present and the AP neither said anything nor asked the resident to touch him.

During an interview, the AP denied having any physical contact with the resident other than to give her medications, empty her garbage and have a brief conversation.

During an interview, the resident stated the AP touched her and, while she did not recall the date, she stated it occurred on a Wednesday.

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.
**Family/Responsible Party interviewed**: No.
**Alleged Perpetrator interviewed**: Yes.

**Action taken by facility:** The facility suspended the AP and conducted an internal investigation. The facility notified the resident's provider and reported the incident to law enforcement.

**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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30599 | A. BUILDING: _____ B. WING _____ | C 02/19/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WHISPERING OAK PLACE | 903 CALVERLY COURT ELLENDALE, MN 56026 |

| (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<br><br>On February 19, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL305997584M /HL305993046C and HL305997324M / HL305992520C. No correction orders are issued. | 0 000 | | |