Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL339262003M
Compliance #: HL339263341C

Date Concluded: May 16, 2025

Name, Address, and County of Licensee Investigated:
Whispering Pines Assisted Living
18660 Simonet Drive
Elk River, MN 55330
Sherburne County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Brooke Anderson, 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 facility neglected the resident when the resident reported feeling very depressed and was found with a knife in his neck.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Upon admission to the facility, nursing staff identified and implemented interventions to address the known vulnerabilities of the resident. Although the incident occurred, the resident's plan of care was followed at the time of the incident. The resident was transported to the hospital for evaluation and treatment and admitted to a psychiatry unit for additional treatment.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the case worker. The investigation included review of the resident record, hospital records, facility internal

investigation documentation, facility incident reports, staff schedules, and related facility policy and procedures. Also, the investigator observed interactions between staff and residents.

The resident resided in an assisted living facility. The resident's diagnoses included paranoid schizophrenia and depression. The resident's service plan included assistance with medication administration and safety checks. The resident's assessment indicated the resident had a history of suicidal ideation.

Documentation indicated while the resident was on the phone with his case manager, the case manager called the facility and reported the resident was feeling depressed and that he had a knife to his neck. Facility management and nursing staff went to check on the resident. The resident was lying on his bed holding a knife that was advanced into his neck on the right side. A large pool of blood was noted. Emergency services was called, and the resident was sent to the hospital.

Hospital records indicated the resident was admitted with a self-inflicted stab injury to his neck with a pocketknife. The resident reported he was distraught because he was told his pension was going to be taken away. The resident remained in the hospital due to continued suicidal thoughts.

During an interview, facility nurse #1 stated the resident was last seen 30 minutes prior to the incident eating lunch. The resident received a phone call from his case manager and the resident shut his door for the conversation. Facility nurse #1 stated the case manager called the facility and requested they go check on the resident.

During an interview, facility nurse #2 stated he received a call from the case manager and requested staff to check on the resident. When the nurses entered the room, the resident had a pocketknife in the right side of his neck. Facility nurse #2 stated he held the resident, so the knife would not penetrate further until the paramedics arrived. Facility nurse #2 stated prior to the incident, interventions for the resident included having the resident's room being near the common area, random room searches, and safety checks.

During an interview, the case manager stated she was on the phone with the resident, and he was upset about having to wait in the emergency room for five hours the night before and hearing he might be losing his pension. The case manager was not sure if he penetrated the knife while she was on the phone with him or when she got off. After she hung up the call with the resident, she called the facility staff to have them check on the resident. The case manager stated she had no concerns with the care the resident received at the facility.

During an interview, a family member stated the resident's usual self-harm method included using medications to overdose, not a knife to cause harm. He felt the resident needed a higher level of care than the facility could provide.

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: No.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility acted immediately and sent the resident to the emergency room.

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
	33926	A. BUILDING: _____ B. WING _____	C 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAKE COTTAGE	18660 SIMONET DRIVE ELK RIVER, MN 55330

(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 On April 29, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL339263341C/#HL339262003M. No correction orders are issued.	0 000		