Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report : HL345267782M
Compliance : HL345268047C

Date Concluded: June 15, 2026

Name, Address, and County of Licensee Investigated:

Empire Systems Home Care
6012 York Avenue North
Brooklyn Center, MN 55429
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Lena Gangestad, 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) sexual abused the resident when he touched her breast, kissed her and asked her to give him a lap dance.

Investigative Findings and Conclusion: The Minnesota Department of Health determined sexual abuse was not substantiated. Due to conflicting accounts of the incidents and insufficient evidence to demonstrate sexual abuse, it could not be determined if maltreatment occurred.

The investigator conducted interviews with administrative staff, the resident, and the AP. The investigation included review of the resident's records, staff schedules, policies, and procedures.

The resident resided in an assisted living facility. The resident's diagnoses generalized anxiety disorder and delusional disorder. The resident's service plan included assistance with behavior management and medication administration.

A concern was reported after the resident contacted law enforcement alleging the AP touched her inappropriately in a sexual manner.

According to the police report, the resident contacted law enforcement to report a sexual assault allegedly occurred between 7:00 p.m. and 8:00 p.m. The resident identified the AP as the alleged offender and stated the incident occurred in her bedroom. The resident told officers she invited the AP to her room to make him a cup of coffee. She stated the AP sat in a pink computer chair and asked her to give him a lap dance. The resident said the AP attempted to dance with her, tried to kiss her, and touched her. She stated the AP grabbed her breast with his right hand in a claw-like grip, moved his hand down her stomach, and touched her vaginal area. The resident further said the AP pulled down his underwear, which she described as gray, exposed his penis, and stated he wanted to have sex. The resident stated she told the AP “No” and she did not want to engage in sexual activity. She said both of them then went upstairs, after which she returned downstairs and called 911.

Law enforcement asked the AP about the color of his underwear. The AP stated his underwear was black and voluntarily lowered his pants to show officers. This differed from the resident’s statement that the underwear was gray.

The police report also documented the AP’s statement. The AP told officers the resident invited him to her room to get a cup of coffee, and he remained there for less than five minutes. He denied asking the resident for a lap dance, exposing himself, or touching her in any inappropriate manner. The AP stated he was surprised the resident contacted police because he had been on FaceTime with the house manager while waiting for the coffee to be brewed. He stated he had no physical contact with the resident other than accepting the cup of coffee.

The police also obtained a statement from the house manager. She said she spoke with the AP on FaceTime for approximately 21 minutes while he administered medication and he remained visible on the screen during the call. She stated after the AP returned upstairs, the resident came upstairs and said, “I am going to bed, goodnight,” while the AP was still on the FaceTime call. The house manager confirmed the AP accepted coffee from the resident and brought it upstairs. She gave her phone to law enforcement, who photographed the call history. The records showed the house manager and the AP were on a phone call beginning at 7:03 p.m. for 21 minutes and that they were on FaceTime from 7:50 p.m. to 8:03 p.m.

During an interview, the resident stated the AP asked her to give him a lap dance and told her he wanted to have sex with her. The resident reported AP exposed his penis and got on top of her. She stated that she told him to leave because she did not want any sexual contact. The resident said she contacted the house manager immediately after the AP left and then called the police. According to the resident, law enforcement advised her to go to the hospital. She stated she did not go immediately but later agreed to do so. The resident said she did not receive any information regarding the hospital evaluation. She stated AP was no longer working at the house she stayed at, and she felt safe.

During an interview, the AP stated he was working in the home with the resident and another resident. He said he was preparing medication for another resident who was in a wheelchair and that the medication regimen was complicated. The AP stated that he initiated a FaceTime call with the house manager for assistance. He said the resident offered him a cup of coffee, and he went to her room to retrieve it. The AP stated he remained in the resident's room for less than one minute before returning upstairs to administer medication and assist the other resident with bedtime. He stated police arrived shortly after he completed those tasks. According to the AP, law enforcement questioned him extensively and asked about the color of his underwear to compare with the resident's description. He reported he was subsequently removed from the home and was no longer assigned to work there.

During an interview, the house manager stated the resident called her and reported the AP had touched her. The house manager stated she told the resident she was on her way to the facility, and the resident then contacted law enforcement. The house manager said upon her arrival, the resident was crying and screaming the AP had tried to rape her. She stated police encouraged the resident to go to the hospital, but the resident initially refused. The house manager also said the AP had been on a video call with her during the period when the resident alleged the assault occurred. She stated police photographed her phone call history. After law enforcement left, the resident took a shower and later stated she wanted to go to the hospital. The house manager said she contacted police again and was advised to transport the resident to the hospital herself, which she did. She stated she did not receive the results of the hospital examination and the resident declined to press charges.

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: Yes.
Family/Responsible Party interviewed: No, the resident was her own person.
Alleged Perpetrator interviewed: Yes.

Action taken by facility: The AP has been removed from the home. The resident was taken to the hospital for evaluation.

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
	34526	A. BUILDING: _____ B. WING _____	C 04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMPIRE SYSTEMS HOME CARE	6012 YORK AVENUE NORTH BROOKLYN CENTER, MN 55429

(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 23, 2026, the Minnesota Department of Health initiated an investigation of complaints #HL345267782M/HL345268047C. No correction orders are issued.	0 000		