Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL306962342M
Compliance #: HL306964109C

Date Concluded: July 25, 2025

Name, Address, and County of Licensee Investigated:
Inver Grove Heights WP LLC
9056 Buchanan Trail
Inver Grove Heights MN, 55077
Dakota County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Kris Detsch, 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) sexually abused the resident when he kissed her and touched her face, arms, legs, and inner thighs.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined sexual abuse was not substantiated. The facility manager observed video footage of the AP during the time the resident made the allegation and did not observe interactions as described by the resident. The resident's care plan was changed to allow female staff only provide cares. Additionally, the actions alleged by the resident did not meet the definition of sexual abuse.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident record(s), facility internal investigation, facility incident reports, personnel files, staff schedules, and

related facility policy and procedures. Also, the investigator toured the facility and observed the facility structure, staffing, and documentation systems.

The resident resided in an assisted living facility. The resident's diagnoses included personality disorder (difficulty understanding emotions) and epilepsy (seizures). The resident's service plan included assistance with meal preparation, housekeeping, and medication administration. The resident's nursing assessment indicated she was alert and orientated. The resident walked independently and completed her own day to day care needs.

During an interview, a manager said the resident told her the AP called her "honey" and "baby." The manager said she told the resident she would tell the AP to stop this behavior. The manager said the resident also told her the AP touched her shoulder and thigh near her knee a couple of days prior, in the hallway, outside of her room. The manager said she observed video footage during the time of the resident's allegations and did not see the AP around the resident.

Facility internal investigation file indicated the manger spoke to other staff members, and the AP about the resident's allegations. The internal investigation indicated the facility was unable to determine what occurred because of conflicting accounts of the incident. There were no camera images of this incident. The investigation indicated the facility would only allow female caregivers to provide care to the resident.

Medical records indicated the facility contacted the resident's mental health provider regarding these concerns. The mental health provider assisted the facility to develop interventions on how to interact with the resident.

The AP's employee file contained a written "warning" document from the manger to him the next day after the resident reported the incident to her. The document indicated the facility required him to communicate properly with the residents. The document contained a section for the AP to make his own comments. The AP denied the allegations made by the resident. The AP's response indicated he did not intend to offend the resident and was only being friendly.

During an interview, the manager said it was days later she passed the resident outside when she mentioned to her, she was uncomfortable with the AP ever since he kissed and grabbed her. The manager said she told the resident she was unaware about those issues because she only told her he called her "nicknames," not kissed her. The manger said she asked the AP what occurred, and he told her he went into the resident's room to help her with her television and held her hand because he did not understand what she needed help with. The AP told the manger he had no other interactions with the resident other than helping her with her television. The manager said the resident told different accounts of the incident, at different times, to different people.

During an interview, a nurse manager said the resident had a history of sexual seeking behaviors. The nurse manger said the facility asked the resident's mental health provider for specific interventions to help address these behaviors.

During an interview, the resident said the AP danced with her at multiple holiday parties. The resident said the AP held and kissed her hand multiple times. The resident said the AP referred to her as his "girlfriend." The resident said she was in another resident's room when the AP entered the room from behind her, put his hands on her waist, and kissed her on the lips. The resident said this occurred once. The resident said the AP left the room but returned to assist the resident with her socks while she sat on the couch. The resident said the AP touched the top of her thigh while she sat on the couch. The resident said she told the manager the next day.

During an interview, the AP said the resident was able to complete her day-to-day cares and she did not require any assistance from staff members. The AP said he was only in the resident's room once because she pushed her call pendant to ask for help getting her television connected with the facility internet. The AP said he never touched the resident. The AP denied kissing, dancing, and referring to her as his girlfriend. The AP denied calling the resident "honey" and "baby." The AP said the manager had a meeting with all facility staff members and reminded them not to use words like "honey" and "baby" when referring to the residents.

In conclusion, the Minnesota Department of Health determined sexual 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;
(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; and
(4) use of any aversive or deprivation procedures for persons with developmental disabilities or related conditions not authorized under section 245.825.
(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: Not Applicable.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility provided education to staff members regarding appropriate communication and contacted mental health providers to help them develop a plan of care.

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
	30696	A. BUILDING: _____ B. WING _____	C 07/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INVER GROVE HEIGHTS WHITE PINE	9056 BUCHANAN TRAIL INVER GROVE HEIGHTS, MN 55077

(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 July 3, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL306964109C/#HL306962342M. No correction orders are issued.	0 000		