Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL306966522M
Compliance #: HL306969724C

Date Concluded: March 31, 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: Willette Shafer, 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 to supervise the residents when resident-2 groped resident-1's breast and grabbed her vagina during a resident gathering in resident-3's apartment.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Several facility staff members observed the four resident's while in resident-3's apartment. Resident-3 and resident-4 had scheduled medication administered while they were in resident-3's apartment during the time of the incident. Resident-1's safety checks were completed and documented per the care plan.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of resident records, facility internal investigation, facility incident reports, personnel files, staff schedules, law enforcement report, related facility policy and procedures. Also, the investigator toured the facility and

observed interactions between staff and residents, the amount of time for staff to answer call lights, and frequency of resident safety checks.

The residents resided in an assisted living facility.

Resident-1's diagnoses included borderline personality disorder, anxiety, depression, adult psychological abuse, and anorexia nervosa. Resident-1's service plan included assistance with medication set-up, meals, bathing cues, reminders to change clothing, grooming, and housekeeping. Resident-1's assessment indicated she was unable to give accurate information consistently, required verbal interventions from staff and safety checks every two hours. Resident-1 was identified as a risk to herself and was vulnerable to abuse or neglect from men online.

The facility's internal investigation indicated resident-1 alleged resident-2 groped her breast and grabbed her vaginal area while at a social gathering in resident-3's apartment. Resdient-1 said the incident was not consensual and resident-2 said the encounter was consensual. A police report was filed, skin assessment was offered to resident-1, and the sexual abuse policy was reviewed.

A law enforcement report indicated while in resident-3's apartment, resident-1 was sitting on a couch next to resident-2. Resident-1 reported resident-2 touched her breast over her shirt and reached down her pants and penetrated her vagina with his fingers. Resident-1 told him to stop. Resident-2 stopped, and resident-1 left resident-3's apartment and went back to her apartment where she vomited in her toilet. Resident-1 reported resident-2 and resident-3 went back to her apartment while she vomited and then left. Resident-3 reported he witnessed resident-2 grope resident-1's breast four times. He said he observed resident-2 put his hand on resident-1's thigh but he never witnessed resident-2 touch resident-1's vaginal area. He reported resident-2 and resident-4 stayed in his apartment after resident-1 left. He denied they followed resident-1 to her apartment. Resident-4 reported she never witnessed resident-2 touch resident-1 but admitted she had memory issues. She reported she went straight to her apartment after she left resident-3's apartment. She never went to resident-1's apartment that evening. Resident-2 stated he touched resident-1's breast over her shirt. He believed it was consensual as resident-1 never told him to stop. He denied he touched her leg or vaginal area. He said resident-1 left resident-3's apartment and he and resident-4 stayed briefly. Resident-2 and resident-4 went to resident-1's apartment to make sure she made it home. Resident-4 helped resident-1 to bed and they both left. Law enforcement contacted a friend of resident-1 who resided outside the facility. Resident-1 contacted the friend the day after the incident. The story resident-1 reported to the friend was different than what resident-1 reported to the police. Resident-1 later called the police and asked to drop the charges as she and resident-2 had talked about the incident and resolved things.

Resident-1's service delivery record indicated reassurance checks were completed every two hours per the resident's care plan on the day of the incident.

Resident-2’s medication administration record indicated he received a blood sugar check and medications multiple times the evening of the incident.

Resident-3’s medication administration record indicated he received medication during the time of the incident.

Resident-4’s medication administration record indicated he received medication during the time of the incident.

The daily assignment sheet indicated five staff worked the evening of the incident.

During an interview, a member of management confirmed five staff worked the evening of the incident and the census was roughly 56 residents. The staff members were aware resident-1, resident-2, and resident-4 were in resident-3’s room. Those four residents were friends and often spent time together. Staff observed the residents in resident-3’s apartment several times while they administered medications to resident-2, resident-3, and resident-4. She said residents have the right to drink alcohol in their apartments and staff know they must report excessive alcohol intake if observed. Residnet-1 reported resident-2 allegedly grabbed her breast and her vaginal area. The incident was reported to the police and an internal investigation was completed.

During an interview, resident-1 said she was hanging out in resident-3’s apartment with resident-2 and resident-4. She said they were drinking alcohol and visiting. She said the four of them frequently hung out together and had no issues in the past. She said resident-2 sat on the couch next her and grabbed her breast and vaginal area. Resident-3 told resident-2 to stop, and resident-2 left. Resident-1 and resident-4 took their clothes off and kissed each other. She said she found out later that resident-3 took pictures of her kissing resident-4. She said she reported this to management after she found out and management searched resdeint-3’s phone but never found any pictures of the incident. She said staff had come into resident-3’s room once or twice to administer medications and check on them. A police report was filed. After a week, she spoke with resident-2, and he apologized. They continued to be friends after the incident.

During an interview, resident-3 said resident-1, resident-2, and resident-4 were all in his apartment drinking. He observed resident-2 grab resident-1’s breast and squeeze her around the waist. He said staff members were in and out of his apartment the evening of the incident.

During an interview, resident-4 said resident-1 was sitting in between her and resident-2 on the couch the evening of the incident. She never observed resident-2 touch resident-1.

During an interview, an unlicensed personnel said she administered medication to resident-2 and resident-4 the evening of the incident. She said she observed the residents in resident-3’s apartment several times during her shift. She said they frequently spent time together and said

there were no issues on the evening of the incident. She said other staff observed the resident's together the evening of the incident and resident-3 had scheduled medications multiple times in the evening. She said resident's receive safety checks every two hours and staff checked on them throughout their shift.

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: Yes.
Family/Responsible Party interviewed: No, attempted but did not reach.
Alleged Perpetrator interviewed: Not applicable.

Action taken by facility:
The facility reported the incident to law enforcement and completed an internal investigation. The facility completed training with all staff and provided education to residents. Resident-1 was offered nursing assessments and the individual abuse prevention plan was updated.

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 03/12/2025

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 ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 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: HL306964420C/HL306968104M HL306969724C/HL306966522M On March 12, 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 58 residents receiving services under the provider's Assisted Living license. The following correction order is issued for HL306964420C/HL306968104M, tag identification 2360. There are no correction orders issued for HL306969724C/HL306966522M.	0 000	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. 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.	
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical,	02360		

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 03/12/2025

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
02360	Continued From page 1 sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility and an individual person were responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		