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

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** HL318841583M
**Compliance #:** HL318842491C

**Date Concluded:** April 29, 2025

**Name, Address, and County of Licensee Investigated:**
River Oaks at Lake Pepin
815 N High St
Lake City, MN 55041
Wabasha 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 facility neglected resident #1 and #2 when it did not adequately supervise resident #1 and resident #2, resulting in an incident of sexual contact in resident #1's apartment.

**Investigative Findings and Conclusion:** The Minnesota Department of Health determined neglect was not substantiated. While it was true sexual contact occurred between resident #1 and resident #2, the residents made decisions consistent with their right to privacy.

The investigator conducted interviews with administrative staff, resident #1 and resident #2. The investigation included review of the resident's records, incident reports, policies, and procedures.

Resident #1 resided in an assisted living facility. The resident's diagnoses schizoaffective disorder and a sexually transmissible condition. The resident's service plan included assistance with managing behaviors and medication administration.

Resident #2 resided in an assisted living facility. The resident's diagnoses generalized anxiety disorder. The resident's service plan included assistance with managing behaviors and medication administration.

The incident report indicated that resident #1 engaged in sexual contact with resident #2 in a few days before resident #1 reported the incident to the manager of the facility. Resident #1 had gone to resident #2's bedroom where the two engaged in sexual contact.

During an interview, the manager stated that resident #1 came to the office and reported sexual contact with resident #2. Resident #1 had a sexually transmissible condition and wanted to inform the facility of what had occurred. The manager stated as soon as the facility became aware of the incident, they interviewed both residents and provided education on safe sex practices. Resident #2 was tested for transmissible diseases, and the results were negative. The manager also stated Resident #2 had a future follow-up test scheduled in three months to confirm no transmission occurred. The manager said both residents felt safe, experienced no distress around each other, and remained friends.

During an interview, resident #1 stated a preference to not talk about the incident anymore, felt safe, and remained friends with resident #2.

During an interview, resident #2 stated sexual contact had occurred with resident #1 on one occasion. Resident #2 stated the friendship with resident #1 remained intact and spoke to each other on a daily basis in a normal manner.

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.

**Alleged Perpetrator interviewed**: Not Applicable.

**Action taken by facility:** The facility filed a report to Minnesota Adult Abuse Reporting Center, interviewed both residents, and educated them about safe sex practices. Resident #2 was tested for any transmissible diseases, and the test results were negative.

**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 |
|---|---|---|---|
| | 31884 | A. BUILDING: _____ B. WING _____ | C 04/23/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| RIVER OAKS AT LAKE PEPIN LLC | 815 NORTH HIGH STREET LAKE CITY, MN 55041 |

| (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 April 23, 2025, the Minnesota Department of Health initiated an investigation of complaints #HL318841583M/HL318842491C . No correction orders are issued. | 0 000 | | |