Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL329383002M
Compliance #: HL329385408C

Date Concluded: August 22, 2025

Name, Address, and County of Licensee Investigated:
A Janesville Senior Living LLC
543 Oakwood Drive
Janesville, MN 56048
Waseca County

Facility Type: Assisted Living Facility with Dementia Care (ALFDC)

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 AP (unknown facility staff member) sexually abused a resident when they attempted to kiss and fondle her.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined sexual abuse was not substantiated. Three months prior to the allegation, the resident told a facility nurse the AP (an unlicensed personnel) sexually assaulted her, so she went to the emergency room (ER) for a sexual assault exam. The exam did not show evidence of a sexual assault. The resident told multiple accounts of the sexual assault to people at different times who then reported the allegations. Law enforcement determined the resident told accounts of the initial allegation. The initial allegation of sexual assault was determined to be unfounded.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted case workers, a medical provider,

and law enforcement. The investigation included review of resident records, hospital records, facility internal investigation, facility incident reports, personnel files, staff schedules, law enforcement report, and related facility policy and procedures. Also, the investigator toured the facility and observed medication administration, meals, documentation systems, and staff interactions with other residents.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia, bipolar disorder (mood disorder), and anxiety. The resident's service plan included assistance with bathing and medication administration. The resident's nursing assessment indicated the resident communicated verbally but was forgetful and had poor decision-making ability. The assessment indicated the resident had verbal outbursts and repetitive thoughts/statements and required psychotropic medications (medications used to treat mental health conditions).

During an interview, a nurse manager said law enforcement came to the facility to interview the resident regarding her allegations of sexual assault. The nurse said law enforcement determined the resident's allegations were from a previous incident which they investigated and determined to be unfounded. The nurse said the initial allegation was months prior to this allegation/investigation.

Physician visit notes indicated the resident's nurse practitioner (NP) evaluated the resident at the facility approximately two hours prior to the resident reporting the initial allegations of sexual assault to the facility staff. NP visit notes indicated she evaluated the resident because the resident recently returned to the facility from the hospital for nausea and altered mental status. The visit notes indicated the resident's family member was present during the NP's evaluation of the resident. The visit notes indicated the resident had chronic (long-term) anxiety and was showering twenty times a day to manage her anxiety. The visit notes indicated the resident's diagnoses included dementia and paranoia due to bipolar disorder. The visit notes indicated the NP changed the resident's mental health medications and requested an evaluation by a psychologist (mental health provider). The visit notes lacked indication the resident told her allegations of sexual assault.

Law enforcement records indicated an officer spoke to the resident the day of the initial allegation. The resident told the officer the AP made both residents drink urine and they both had balls attached to a string in their vaginas. The records indicated the resident told the officer the AP licked her vagina and licked the other resident's stomach. The records indicated the resident said the incident occurred a couple of weeks prior. A family member was with the resident at the time the law enforcement officer was there, and the family member told the officer the resident told her she showered and removed the balls from her vagina then placed them on the shower chair. The family member told the officer she went to the bathroom and did not see the balls on the shower chair. The family member said the resident then told her the balls were in a cup, but there were no balls in a cup. The family member told law enforcement the resident was having a psychotic episode. The law enforcement officer spoke to the hospital

staff, and they determined there were no balls with a string inside the resident, and there was no evidence of trauma/sexual assault. The hospital staff told the officer they would continue to observe the resident and have further geriatric evaluations conducted.

Additional law enforcement records indicated there were other allegations from the resident about this same incident. The records indicated the AP licked the resident's cheeks, breasts, stomach, buttocks, and back. The resident said the AP slapped her in the face and spanked her. The resident said there were three silver balls attached to a string and the AP placed them into her (the resident's) vagina, took them out and hit her with them. The resident said the urine came out of her nose when she drank it. The resident said this behavior occurred nearly every day.

Hospital records indicated there was no evidence a sexual assault occurred. Hospital records indicated the resident's behavior and fixed beliefs were consistent symptoms of dementia.

During an interview, a former nurse manager said she worked at the time of the resident's initial allegation. The nurse manager said the resident told her the AP brought another resident into her room and sexually assaulted them both. The nurse manager said she told the facility director what occurred and called law enforcement who then came to the facility to interview the residents. The nurse manager said she sent both residents to the emergency room (ER) for evaluation. The nurse manager said the resident was in the ER multiple times within the week prior to this allegation for various health concerns. The nurse manager said prior to this allegation, the resident's toxicology (lab) reports indicated she used street drugs including methamphetamine. The nurse manager said the residents returned to the facility after the ER determined there was a lack of evidence a sexual assault occurred.

During an interview, the former facility director said she removed the AP from the schedule and told law enforcement to contact her. The director said law enforcement "cleared" the AP to return to work. The director said after the initial allegation, the resident left the hospital and stayed with her family, then returned to the facility. The director said the AP worked on second floor, so they offered the resident a room on the first floor. The director said the facility kept the AP working night shifts on the second floor, separate from the resident.

During an interview, the AP said she worked in the dietary department at a facility the resident lived prior to this facility, but her only interactions with her during this time were regarding food service. The AP said the resident moved into this (current) facility prior to the AP's start of employment there. The AP said she worked the night shifts and had only seen/interacted with the resident twice before the resident made these allegations, and both times other staff were present. The AP said these interactions occurred in the common areas of the facility. The AP said she never entered the resident's room because the resident did not receive any services during the night. The AP said she did not work for three days prior to the date of the allegation but she was supposed to work on the night shift the day the resident made the allegations; however, leadership told her not to come into work because they needed to investigate an

allegation of abuse. The AP said she had no knowledge about what the specific allegations were. The AP said a law enforcement officer came to her house and asked her to go to the police station to answer their questions. The AP said law enforcement cleared her to go back to work. The AP said she heard about specific allegations from another co-worker who told her what the resident said, after she returned to work. The AP denied the allegations and denied ever going into the resident's room.

During consultation with law enforcement, the resident continues to tell people about the initial allegations of sexual assault prompting new investigations. Law enforcement previously investigated the initial allegations of sexual assault and determined the allegation to be unfounded.

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: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility separated the resident and the AP, and coordinated health care for the resident.

Action taken by the Minnesota Department of Health:
The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

You may also call 651-201-4200 to receive a copy via mail or email

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
	32938	A. BUILDING: _____ B. WING _____	C 08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A JANESVILLE SENIOR LIVING LLC	543 OAKWOOD DRIVE JANESVILLE, MN 56048

(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: HL329385408C/HL329383002M HL329384207C/HL329382362M On August 7, 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 thirty-three residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for HL329385408C/HL329383002M, tag identification 630. No correction order is issued for HL329384207C/HL329382362M.	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.	
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma	0 630		

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0 630	Continued From page 1 (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to update an individual abuse prevention plan (IAPP) and failed to implement person centered individual interventions after sexual assault allegations, delusional behavior (psychosis), and street drug use for one of two residents (R1) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 admitted to the licensee on for diagnoses including bipolar two disorder and anxiety. R1's service plan dated August 7, 2025, (effective date) indicated she required assistance with bed	0 630		

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0 630	Continued From page 2 making, transportation, bathing, meals, housekeeping, laundry, medication administration, safety checks, and behavior management. The service plan indicated interventions for behavior management indicated R1 was verbally aggressive towards others, and demanding to staff regarding food items. The service plan indicated staff should assist her to relax with music or television, take her dog outside, and re-approach. The service plan indicated, the licensee added a behavior management service on March 3, 2025, to include two staff members for all cares and medication administration. Law enforcement records dated February 19, 2025, indicated they went to the licensee because R1 alleged unlicensed personnel (ULP)-H sexually assaulted her. The records indicated R1 told the law enforcement officer ULP-H put her fingers and balls attached to a string in her vagina and forced R1 and another resident to drink urine. R1 told the law enforcement officer ULP-H licked her vagina, and the other resident's stomach. The records indicated both residents went to the hospital for a sexual assault examination. Law enforcement records indicated there was no evidence a sexual assault occurred. R1's IAPP dated February 19, 2025, indicated R1 had poor memory, and required re-direction. The IAPP indicated she had impulse control issues. The IAPP indicated R1 had no chemical and/or other medication abuse. The IAPP failed to indicated R1 had an allegation of sexual abuse and individualized interventions to protect R1 from abuse and address any behaviors of accusations. Progress notes dated February 20, 2025, at 4:37	0 630		

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0 630	Continued From page 3 p.m., read, "drug seeking noted." No further documentation or information regarding the notation. R1's nursing assessment dated March 3, 2025, indicated R1 had cognitive decline, bipolar two disorder, and anxiety issues. The assessment indicated R1 scored 18/30 on MOCHA test (memory test indicting mild memory impairment). The assessment indicated R1 had verbal outbursts, repetitive thoughts/statements, and socially inappropriate behaviors. R1 required occasional redirection due to "vaping" in the hallways, and her demanding behavior. The nursing assessment indicated R1 had no history of miss use or drug diversion. The assessment failed to identify R1 used street drugs including methamphetamine. The assessment failed to identify R1 had a pain contract with a physician at a pain clinic. The assessment failed to identify R1 had a history of unfounded allegations of sexual assault. The nursing assessment failed to identify how R1's delusional behavior impacted other resident's and failed to identify person centered individualized interventions to mitigate the risk of harm to others. R1's physician visit record dated April 3, 2025, at 10:00 a.m., indicated R1 tested positive for benzodiazapines, amphetamines, opiates, and methamphetamines on February 9, 2025. The record indicated R1 had a pain contract, which R1 avoided due to the positive lab results. The record indicated R1 had dementia, paranoia due to bipolar disorder and required psychotropic medication to manage this. R1's IAPP failed to be updated with to accurately reflect R1's self abuse related to drug use when R1 tested positive for methamphetamines on	0 630		

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0 630	Continued From page 4 February 9, 2025. The IAPP failed to identify R1 had a pain contract with a physician at a pain clinic. The IAPP lacked person centered individualized interventions to minimize R1's risk of harm due to use of methamphetamines. The IAPP failed to identify measures to monitor, manage, or coordinate care according to R1's pain contract. On August 7, 2025, at 2:01 p.m., director of nursing (DON)-A said he started working at the licensee after these instances occurred. DON-A said he heard from other staff members R1 had an extensive history of drug abuse and left the licensee's building with other people and returned appearing "sedated," so staff suspected drug use. DON-A said this was just "hearsay," however this led him to investigate her medical records, and he found the pain management clinic discontinued R1's pain contract because of her continued opioid drug use. DON-A said the pain contract violation occurred prior to his employment. On August 18, 2025, at 3:25 p.m., the surveyor asked DON-A to confirm if the IAPP dated February 19, 2025, was the only IAPP completed by the licensee. DON-A said he would double check to confirm, however he said he believed it was. DON-A said this was due to a lot of circumstances. DON-A said he did not complete an IAPP for the resident since he started working mid-April 2025. On August 19, 2025, at 8:48 a.m. DON-A confirmed R1 had no further IAPP assessments. The licensee's policy titled, Individual Abuse Prevention Plans, dated November 7, 2024, indicated the IAPP would include specific measures to minimize the resident's risk of	0 630		

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0 630	Continued From page 5 abuse. TIME PERIOD OF CORRECTION: Seven (7) Days	0 630		