Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL369224944M
Compliance #: HL369221185C

Date Concluded: October 29, 2025

Name, Address, and County of Licensee Investigated:
Sunshine Group Home
125 Magnolia Avenue West
St. Paul, MN 55117
Ramsey County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Peggy L Boeck
Special Investigator

Finding: Inconclusive

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) abused a resident when the AP intentionally touched the breast of the resident.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was inconclusive. The resident stated the incident occurred, the AP stated the incident did not occur. There was no witnesses or supporting evidence of the alleged incident. Audio from surveillance video provided no confirmatory evidence.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement. The investigation included review of the resident record, facility internal investigation, facility incident reports, personnel files, staff schedules, surveillance video, law enforcement report,

related facility policy and procedures. Also, the investigator observed staff/resident interactions.

The resident lived in an assisted living facility due to diagnoses that included depression, anxiety, paranoia, and schizoaffective disorder, bi-polar type. The resident's service plan included assistance with reminders for activities of daily living, and medication administration, behavior management, and mental health interventions. The resident's assessment indicated the resident struggled with paranoia, difficulty trusting others, and hallucinations.

An incident report written by the AP indicated one night the resident was agitated, talking to herself, and had a panic attack. The report indicated the AP tried to verbally calm the resident. The AP asked the resident to go outside to smoke (as she had been smoking in the living room) and attempted to talk with the resident while both were outside. The report indicated the resident stated the AP touched her inappropriately, which the AP denied. The report indicated the AP stated he verbally tried to calm the resident, made no physical contact, and reported the incident to his supervisor.

A facility document indicated the supervisor placed the AP on leave of absence pending investigation.

An investigation document indicated the supervisor met with the resident later in the day and she was upset and disoriented. The document indicated the resident was having a mental health crisis, so the supervisor called the crisis line. Law enforcement responded along with an ambulance to assess the resident, but the resident refused to participate or go to the hospital. The report indicated the supervisor and nurse planned to review security camera footage.

An investigation report indicated review of the facility security camera showed the resident and AP exit the front door of the facility but were then out of camera view. The investigation indicated the security footage captured audio of the resident and the AP speaking of spirituality and spiritual beliefs. The report indicated an audible slap sound was heard followed by the resident accusing the AP of inappropriately touching her, to which the AP is heard immediately responding "I did not touch you." The report indicated the two continued talking including non-reality-based statements by the resident about god and satan. The resident was laughing, but calmly repeated the claim of inappropriate touch by the AP. The resident and AP then went back into the facility.

The investigation report indicated the resident contacted law enforcement the next day. Officers reviewed and obtained the camera footage and took the resident's statement. Officers offered to transport the resident to the hospital and the resident declined. The resident then left the facility with a friend.

A law enforcement report indicated the incident was under investigation.

During an interview, an administrator stated although there was no video evidence and he felt the audio did not provide conclusive evidence, the facility decided to terminate the AP out of an abundance of caution.

During an interview, a licensed staff stated the resident had been off medications for a time prior to the incident and had a negative interaction with her psychiatrist which seemed to trigger mental health symptoms shortly before the incident.

During investigative interviews, several staff members stated the resident had not consistently taken her medications before the incident and had some difficult behaviors. Staff stated the resident “was not herself” when off medications but was generally a kind and pleasant person.

During an interview, the resident stated the AP had asked for a hug and when the resident leaned in, the AP intentionally grabbed her right breast. The resident stated she had a history of assault and became upset, so left the facility. The resident stated she asked to return about a month later after hearing that the AP no longer worked at the facility.

Review of the surveillance video provided no audio evidence of the hug request, but did include the resident’s verbal accusation, the AP’s denial, and ongoing conversation of unrelated topics.

During a phone conversation, the AP stated he did not want to interview and directed the investigator to his documentation of the incident. During another call from the AP, the AP stated he worked at the facility for several years and never had an accusation like this. The AP stated he did not understand why the facility terminated him.

In conclusion, the Minnesota Department of Health determined abuse was inconclusive.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or 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 family identified.
Alleged Perpetrator interviewed: The AP spoke briefly with the investigator twice but chose not to formally interview.

Action taken by facility:
The AP is no longer employed by the facility. The facility provided training to all staff on boundaries, resident rights, the Vulnerable Adult Act, safe overnight procedures, documentation, and responding to mental health crises.

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
	36922	A. BUILDING: _____ B. WING _____	C 09/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE GROUP HOME LLC	125 MAGNOLIA AVENUE WEST SAINT PAUL, MN 55117

(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 September 30, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL369221185C/#HL369224944M. No correction orders are issued.	0 000		