

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #: H81136331M**  
**Compliance #: H81139457C**

**Date Concluded:** January 7, 2025

**Name, Address, and County of Licensee**

**Investigated:**

Alliance HHC and Nursing Service  
10405 6th Avenue North Ste 105  
Plymouth MN 55441  
Hennepin County

**Facility Type:** Home Health Agency (HHA)

**Evaluator's Name:** Holly German, RN  
Special Investigator

**Finding:** Substantiated, individual responsibility

**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 client when the AP made inappropriate sexual advances towards the client. The AP and the client had sexual intercourse on more than one occasion.

**Investigative Findings and Conclusion:**

The Minnesota Department of Health determined sexual abuse was substantiated. The AP was responsible for the maltreatment. The AP, who was a registered nurse, indicated in a written statement that she had sex with the client.

The investigator conducted interviews with agency nursing staff, another agency client, the client, and the AP. The investigator contacted law enforcement. The investigation included review of the client's records, facility internal investigation, facility incident reports, personnel files, and related facility policy and procedures.

The client received comprehensive basic home care services in their home. The client's diagnoses included muscle wasting and atrophy, and depression. The client's service plan included assistance with medication management and performing range of motion exercises. The client's assessment indicated he was alert, oriented, and used a walker for ambulation.

The client's plan of care indicated the client received skilled nursing visits from the agency staff two times a week, and up to six additional visits as needed for health changes. The plan indicated the client would receive a skilled nursing visit every 56-60 days for the recertification of services.

The client's service schedule indicated the AP completed three home service visits to the client over a four-month time span.

The agency's incident report indicated the client called the agency and stated the AP was being sexually inappropriate toward him during nursing visits. The client stated sexual contact occurred and he felt pressured. The report indicated the agency contacted the AP, who stated she and the client were engaged in a "relationship." The AP was suspended pending investigation.

The agency's interview notes from the interview of the client indicated the client said the AP made inappropriate sexual advances toward him during nursing visits beginning three months earlier. The notes indicated the client said he and the AP had sexual intercourse three times, of which the last time was five days prior to the interview. The notes indicated the client stated the intercourse occurred during the scheduled nursing visits, and the client did not feel he and the AP were in a relationship.

A typed statement provided by the AP indicated the AP stated during the first visit with the client, the client told the AP he was attracted to her, and the client leaned on the AP against the wall and hugged the AP. The statement indicated the AP began to receive personal text messages from the client that included statements of calling the AP a "sexy woman" and an "extremely beautiful woman." The AP's statement indicated the client requested her to send him pictures of herself and the messages became more sexually explicit. The statement indicated the client began to send text messages to the AP requesting the AP to send him money via an online cash application, which the AP did on multiple occasions. The statement indicated the AP visited the client 10 to 15 times outside of professional purpose visits over a three-month time frame. The AP's statement indicated during an after-hours visit with the client, she was confronted by another female who arrived at the client's home. The statement indicated the woman stated she was in a relationship with the client for 11 years and in talking, the woman and the AP figured out the client had been having sex with each of them.

During an interview, a licensed practical nurse (LPN)-1 stated she received a call from the client where he stated the AP had made sexual advances towards him. LPN 1 stated the client told her that he and the AP had sexual intercourse three times during scheduled service visits. LPN 1

stated the client seemed evasive when trying to get information from him. LPN 1 stated she felt the AP was a very good nurse who cared about the people she gave services to and there had not been any previous complaints or concerns about the AP. LPN 1 stated the AP stated during an interview that she and the client were in a relationship, and she knew it was wrong. LPN 1 stated the AP told her when the AP attempted to end the relationship with the client, he became very aggressive and threatening towards the AP. LPN 1 stated the AP did not admit to sexual intercourse during their interview.

During an interview, LPN 2 stated she had been working with the client for about four years. LPN 2 stated the client never said anything to her about having concerns about the AP.

During an interview, the client stated he reported the AP for inappropriate sexual stuff and touching that occurred four to five times. The client stated the AP asked him to not say anything about their relationship and stated the AP stated she would lose her license. The client stated he did not want to discuss the allegations any further due to being uncomfortable saying it.

In a written interview questionnaire given to the AP from the investigator, the AP was asked to describe workplace boundaries the AP's employer directed for a staff member to participate regarding meeting with clients outside of work hours and to participate in personal relationships with the client. The AP indicated her employer told her to avoid Facebook friend requests from patients. The AP was asked additional questions regarding the relationship she had with the AP, and for clarifications of her previously written statements in which the AP declined to answer sighting her fifth amendment right to remain silent.

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

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.

"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

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;

(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:

(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.

**Mitigating Factors considered, Minnesota Statutes, section 626.557, Subd. 9c(f):**

(1) The AP did not follow an erroneous order, direction or care plan with awareness and failure to take action.

The AP did not direct an erroneous order, direction, or care plan.

(2) The agency was in compliance with regulatory standards.

The agency provided proper training and/or supervision of staff.

The agency provided adequate staffing levels.

The AP failed to follow the agency directive and/or policies and procedures.

The AP did not have the authority to direct and implement operational regulatory requirements or make operational changes.

(3) The AP failed to follow professional standards and/or exercise professional judgement.

The AP failed to act in good faith interest of the vulnerable adult.

The maltreatment was not a sudden or foreseen event.

**Vulnerable Adult interviewed:** Yes.

**Family/Responsible Party interviewed:** Not applicable

**Alleged Perpetrator interviewed:** Yes.

**Action taken by facility:**

The agency suspended the AP pending the investigation.

**Action taken by the Minnesota Department of Health:**

MDH previously investigated the issue during a complaint survey under federal regulations, and substantiated facility 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>.

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

The purpose of this investigation was to determine any individual responsibility for alleged maltreatment under Minn. Stat. 626.557, the Maltreatment of Vulnerable Adults Act.

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to

the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc:

The Office of Ombudsman for Long Term Care

The Office of Ombudsman for Mental Health and Developmental Disabilities

Hennepin County Attorney

Plymouth City Attorney

Plymouth Police Department

Minnesota Board of Nursing

Minnesota State Department of Health

<b>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</b>		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: <b>25403</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED <b>12/06/2024</b>
NAME OF PROVIDER OR SUPPLIER <b>ALLIANCE HHC &amp; NURSING SERVICE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>10405 6th Ave N, STE 105 , Plymouth, Minnesota, 55441</b>	
(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) COMPLETION DATE
00000	Initial Comments  The Minnesota Department of Health investigated an allegation of maltreatment, complaint H81136331M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557.  The following correction order is issued for #H81136331M, tag identification 325.	00000		
00325	Free From Maltreatment  CFR(s): 144A.44, Subd. 1(a)(14)  be free from physical and verbal abuse, neglect, financial exploitation, and all forms of maltreatment covered under the Vulnerable Adults Act and the Maltreatment of Minors Act  This LICENSURE REQUIREMENT is NOT MET as evidenced by:  The facility failed to ensure one of one client reviewed (C1) was free from maltreatment.  The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual person was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	00325		

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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