Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL206199322M
Compliance #: HL206193435C

Date Concluded: March 31, 2026

Name, Address, and County of Licensee Investigated:
Ridgeview Place Senior Living
1009 10th Ave. NE 121
Sauk Rapids, MN 56379
Benton County

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

Evaluator's Name:
Jana Wegener, 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) abused the resident when she grabbed the resident on his buttocks and made inappropriate comments that made the resident feel uncomfortable.

Investigative Findings and Conclusion: The Minnesota Department of Health determined abuse was substantiated. The AP was responsible for sexual abuse. The resident stated the AP straddled his legs and hovered over him in his recliner while making comments about wanting to sleep with the resident which made him feel uncomfortable. Then the AP reached into the recliner, grabbed the resident's buttocks in a sexual manner and squeezed while stating, "there, that ought to make you smile". The resident's wife witnessed the incident and her statement aligned with the resident's. The AP denied the allegation.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement, and the resident's provider. The investigation included review of the resident record(s), medical records,

facility internal investigation, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed residents and staff at the facility.

The resident resided in an assisted living facility with diagnoses including Cerebral Palsy, generalized anxiety disorder, and colon cancer. The resident's assessment indicated he was cognitively intact and able to report concerns of abuse.

A concern arose when the facility received reports the AP, an unlicensed personnel, made inappropriate sexual comments to the resident and touched is buttocks in a sexual way.

The resident's progress notes indicated reported the resident had an inappropriate encounter with another staff member [the AP] the previous day when the resident's spouse was present. The progress notes indicated the resident had no bruising or physical signs of abuse but reported anxiety and inability to sleep following the incident.

The resident's medication administration record (MAR) indicated the AP documented providing medication administration to the resident at 6:50 p.m. the day the incident occurred.

A facility investigation indicated the AP had flirtatious inappropriate conduct including standing over the resident with unnecessary close contact then touched, grabbed, and squeezed the resident's buttocks. The investigation indicated when interviewed about the incident the resident stated while he was resting in his recliner the AP got close to him and said, "you haven't smiled for me all shift, where is your smile for me?" Then proceeded to reach down and grab the resident's hip and buttocks area and squeezed stating, "well that will give you a smile!" The resident stated the AP then said something "creepy" like "you look pretty cozy and warm in your chair; I'm going to crawl up next to you and take a nap". The resident stated he responded, "my wife would not appreciate that", and the AP shrugged then left the room. The investigation indicated the resident's wife witnessed the incident and stated she saw the AP reach into the resident's recliner and "grabbed his ass" and said, "that will make you smile". The resident's wife stated the resident's eyes got wide like what just happened. The resident's wife stated the AP made a comment about wanting to cuddle up and sleep with the resident in his chair which was creepy and made them both feel uncomfortable. The investigation indicated during a facility interview the AP admitted she "tried to get the resident to smile by touching his leg" and said "that ought to make you smile" but denied grabbing and squeezing the resident's buttocks. The investigation indicated the AP stated she had not intended to make the resident feel uncomfortable and was not trying to be inappropriate and apologized.

When interviewed facility leadership stated the resident was a reliable reporter of abuse and had no history or pattern of abuse allegations.

During an interview, a unlicensed personnel (ULP) stated when she was in the resident's room the following morning the resident's wife asked if the resident had told her what happened with the AP last evening. The resident's wife stated when the AP entered the room to pass

evening medications, she mentioned how the resident had not smiled for her shift and touched him inappropriately and said, “that will give you a smile”. The staff stated she then asked the resident to tell her what happened and the resident reported the AP grasped his buttocks and said, “that should make you smile”. The resident stated the AP then said she wanted to snuggle up and take a nap with him to which the resident responded, “my wife would not appreciate that”, then the AP left. The resident stated the interaction made him feel very uncomfortable and they did not want the AP in their room anymore.

When interviewed the AP denied the allegation and stated she only touched the resident on the knee but did not grab or squeeze his bottom, which did not align with her previous statement to facility leadership. The AP denied making inappropriate statements, then stated she had a friendly relationship with the resident, and they had made mutually inappropriate jokes and statements during casual conversations. The AP did not elaborate on what inappropriate jokes/statements were made and stated she did not recall.

When interviewed the resident stated the day of the incident he had just returned from having chemotherapy and was resting in his recliner when the AP entered his room and straddled his legs in the recliner, hovered over him, and asked, “what was wrong, why aren’t you smiling”. The resident stated then AP made comments about wanting to crawl into the chair with him, to which he responded, “my wife would not like that”, and the AP left the room. The resident stated the interaction made him feel very uncomfortable but indicated it was not the first time the AP’s interactions and statements had made him feel uncomfortable. The resident stated when the AP returned, she sat on the arm of his recliner chair, reached down into the left side of his recliner chair, grabbed his left buttocks cheek, and ran her hand down his leg toward his groin in a sexual manner and said “there, that ought to make you smile”. The resident stated the incident had caused increased anxiety and difficulty sleeping related to nightmares about the incident with the AP.

When interviewed the resident’s wife stated she observed the AP’s inappropriate interactions toward the resident and demonstrated how the AP straddled the resident’s legs and leaned over his body in the recliner, then made sexual advances when she reached into the chair to grab the resident’s buttocks. The resident’s wife stated they were shocked by what had happened and reported the incident.

When interviewed the resident’s provider indicated the resident was struggling with anxiety and depression following a cancer diagnosis at the time the incident with the AP occurred. The provider stated the incident with the AP had affected the resident’s mood adversely and indicated the resident was receiving services to help manage his symptoms.

In conclusion, the Minnesota Department of Health determined 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:
(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.

Section 609.341 Subd. 5.Intimate parts.
"Intimate parts" includes the primary genital area, groin, inner thigh, buttocks, or breast of a human being.

Section 609.341 Subd. 11.Sexual contact.
(a) "Sexual contact," for the purposes of sections 609.343, subdivision 1, clauses (a) to (e), and subdivision 1a, clauses (a) to (f) and (i), and 609.345, subdivision 1, clauses (a) to (d) and (i), and subdivision 1a, clauses (a) to (e), (h), and (i), includes any of the following acts committed without the complainant's consent, except in those cases where consent is not a defense, and committed with sexual or aggressive intent:
(i) the intentional touching by the actor of the complainant's intimate parts, or
(ii) the touching by the complainant of the actor's, the complainant's, or another's intimate parts effected by a person in a current or recent position of authority, or by coercion, or by inducement if the complainant is under 14 years of age or mentally impaired, or
(iii) the touching by another of the complainant's intimate parts effected by coercion or by a person in a current or recent position of authority, or
(iv) in any of the cases above, the touching of the clothing covering the immediate area of the intimate parts, or
(v) the intentional touching with seminal fluid or sperm by the actor of the complainant's body or the clothing covering the complainant's body.

(b) "Sexual contact," for the purposes of sections 609.343, subdivision 1a, clauses (g) and (h), 609.345, subdivision 1a, clauses (f) and (g), and 609.3458, includes any of the following acts committed with sexual or aggressive intent:
(i) the intentional touching by the actor of the complainant's intimate parts;
(ii) the touching by the complainant of the actor's, the complainant's, or another's intimate parts;
(iii) the touching by another of the complainant's intimate parts;
(iv) in any of the cases listed above, touching of the clothing covering the immediate area of the intimate parts; or
(v) the intentional touching with seminal fluid or sperm by the actor of the complainant's body or the clothing covering the complainant's body.

Vulnerable Adult interviewed: Yes
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility: The facility reported the incident to the Minnesota Adult Abuse Reporting Center (MAARC) and law enforcement, investigated the incident, provided resources to the resident following the incident, and re-educated staff on abuse and inappropriate conduct. The AP is no longer employed by the facility.

Action taken by the Minnesota Department of Health: The facility was issued a correction order regarding the vulnerable adult's right to be free from maltreatment.

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 responsible party will be notified of their right to appeal the maltreatment finding. If 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
Benton County Attorney
Sauk Rapids City Attorney
Sauk Rapids Police Department
Department of Human Services (DHS)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20619	A. BUILDING: _____ B. WING _____	C 01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGEVIEW SENIOR LIVING	1009 10TH AVENUE NE SAINT JOSEPH, MN 56374

(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****** HOME CARE PROVIDER/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: #HL206199322M/#HL206193435C On January 30, 2026, 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 42 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued/orders are issued for #HL206199322M/#HL206193435C, tag identification 2360.	0 000		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act.	02360		

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02360	Continued From page 1 This MN Requirement is not met as evidenced by: Based on interviews and document review, the licensee failed to ensure one of one residents (R1) reviewed was free from maltreatment, R1 was abused. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, a individual was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360	Refer to the maltreatment public report sent separately.	