Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL291032340M
Compliance #: HL291038480C

Date Concluded: May 7, 2026

Name, Address, and County of Licensee Investigated:
Carefree Living
1 Central Boulevard
Babbitt, MN 55706
St. Louis 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 the AP was observed intentionally slapping the resident's buttocks while providing incontinence care.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was substantiated. The AP was responsible for the maltreatment. Staff observed the AP slap the resident's bare buttocks when incontinence care was provided then stated, "I could not help myself." The AP admitted intentionally "smacking" the resident's naked buttocks during cares.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident record, facility internal investigation, facility incident reports, 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 acquired absence of the right and left lower extremities, depression, anxiety disorder, and rheumatoid arthritis.

The resident's assessment and service plan indicated he required staff assistance with medication administration services, bed mobility, transfers, dressing, and incontinence care. The service plan directed staff to prioritize the resident's comfort, privacy, safety, well-being, and dignity during cares.

A facility complaint form indicated the resident's pendant call light was going off, staff responded, knocked on the resident's door and entered the room. The form indicated staff observed the AP providing incontinence care to the resident, applied ointment, then "spanked" the resident's naked buttocks and giggled while saying, "I just couldn't help myself."

A facility incident report indicated unwanted sexual contact occurred during the incident. The incident report indicated while the AP provided cares to the resident in bed another staff witnessed the AP slapping the resident's buttocks then stated, "I couldn't help myself." Staff reported the resident appeared surprised immediately after the interaction. The incident report indicated the resident declined to speak about the incident.

A post incident assessment indicated the resident had no redness, bruising, or changes in mood following the incident, however it was completed 10 days after the incident occurred. The assessment indicated when interviewed the resident stated, "nothing happened, we were just messing around!"

A facility investigation indicated the AP was aware the other staff member was in the room at the time the incident occurred. The investigation indicated the AP touched the resident in a sexual manner by slapping him on the buttocks and admitted the incident occurred.

When interviewed, facility leadership stated the staff witness reported the resident initially appeared shocked after the AP slapped his buttocks, then did not want to respond to questions about the incident during their investigation.

When interviewed, the staff witness stated she observed the resident bent over naked on the bed while the AP provided incontinence care. The witness stated she was shocked when the AP slapped the resident on his naked buttocks then giggled and said, "I just could not help myself." The staff stated she reported the incident immediately and was directed to complete a facility complaint form.

When interviewed, the AP stated she had a close relationship with the resident and often joked around with him. The AP stated the resident made jokes about her breasts. The AP stated while the resident was in a bent over position so she could provide incontinence care, the resident made a comment toward her about her breast, and she responded by lightly "smacking" the

resident's naked buttocks in a joking manner. The AP indicated she knew she should not have slapped the resident's buttocks. The AP indicated the resident laughed after she slapped his buttocks and stated, "that was the closest thing to a woman's touch he was going to get."

When interviewed, the resident stated the AP was his friend and he felt the incident was blown out of proportion. The resident stated the AP washed his private parts then swatted his backside but did not mean anything by it. The resident denied the incident had caused him pain or made him feel uncomfortable.

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. 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:
(i) the intentional touching by the actor of the complainant's intimate parts, 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.

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

Vulnerable Adult interviewed: Yes.
Family/Responsible Party interviewed: Not applicable, resident was his own responsible party.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility investigated the incident. The AP is no longer employed by the facility.

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

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
St. Lois County Attorney
Babbitt City Attorney
Babbitt Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29103	A. BUILDING: _____ B. WING _____	C 04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BABBITT CAREFREE LIVING BY OXFORD LIVI	1 CENTRAL BOULEVARD BABBITT, MN 55706

(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: HL291038480C/HL291032340M On April 1, 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 27 residents receiving services under the Assisted Living with Dementia Care license. The following correction order is issued/orders are issued for HL291038480C/HL291032340M, tag identification 0630, and 2360.	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=G	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 identify and implement specific measures to reduce residents risk for abuse and ensure resident safety for one of one resident's (R1) reviewed for maltreatment. Unlicensed personnel (ULP)-B witnessed ULP-A sexually abuse R1 and reported to management. ULP-A was allowed to have continued access to and provided cares to R1. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) 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 was admitted to the licensee on June 5, 2024, with diagnoses including acquired absence of the right and left lower extremities, depression, anxiety disorder, and rheumatoid arthritis.	0 630		

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0 630	Continued From page 2 R1's service plan effective February 21, 2026, indicated R1 required staff assistance with medication administration services, bed mobility, transfers, dressing, and incontinence care. The service plan directed staff to prioritize R1's comfort, privacy, safety, well-being, and dignity during cares. R1's assessment and individual abuse prevention plan (IAPP) dated February 3, 2026, identified R1 was at risk for abuse due to physical impairment. The IAPP indicated staff would monitor and report signs and symptoms of abuse or neglect from others and report promptly to ensure the resident would remain free from abuse or neglect while residing in the facility. On February 21, 2026, a facility complaint form completed by ULP-B indicated R1's pendant call light was going off, so she responded, knocked on R1's door and entered the room. The form indicated ULP-B observed ULP-A providing incontinence care to R1 while he was bent over in bed, applied ointment, then "spanked" R1's naked buttocks and giggled while saying, "I just couldn't help myself." A incident report dated February 21, 2026, indicated R1 had unwanted sexual contact from ULP-A. The incident report completed by registered nurse interim Director of Nurses (RNDON)-D indicated she was notified of the incident on February 23, 2026, at 10:30 a.m. However, the incident report was not completed until March 5, 2026, 12 days after the incident occurred, and 10 days after RNDON-D was made aware of the incident. The incident report indicated while ULP-A provided cares to R1 in bed another staff ULP-B witnessed ULP-A	0 630		

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0 630	Continued From page 3 slapping R1's buttocks then stated, "I couldn't help myself". The incident report indicated a facility RN was notified of the incident immediately following the incident on February 21, 2026, at approximately 10:30 a.m. and an internal investigation was initiated at that time. An undated facility investigation summary indicated ULP-A touched R1 in a sexual manner when she slapped R1 on the buttocks while providing incontinence care. R1's change of condition post incident assessment dated March 3, 2026, by RNDON-D indicated R1 had no redness, bruising, or changes in mood following the incident. The assessment indicated when interviewed R1 stated, "nothing happened, we were just messing around!" The assessment failed to indicate any changes were made to R1's IAPP following the incident including the abuse and actions taken to prevent recurrence and ensure R1 and other residents were safe. A review of ULP-A's time clock punches indicated she worked the remainder of her shift after the incident with access to R1 and other residents, then remained on the schedule for 10 days following days: On February 21, 2026, ULP-A punched in for her shift at 5:45 a.m., and punched out at 2:15 p.m. the day of the incident. On February 22, 2026, ULP-A punched in for her shift at 5:45 a.m., and punched out at 2:00 p.m. On February 23, 2026, the day RNDON-D was made aware of the incident, ULP-A punched in for her shift at 6:00 a.m. 2:15 p.m. On February 24, 2026, ULP-A punched in for her shift at 6:00 a.m., and punched out at 2:15 p.m. On February 26, 2026, ULP-A punched in for her	0 630		

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0 630	Continued From page 4 shift at 6:00 a.m., and punched out at 2:45 p.m. On February 27, 2026, ULP-A punched in for her shift at 6:00 a.m., and punched out at 2:15 p.m. The same day ULP-A punched in at 6:45 p.m., and punched out at 9:45 p.m. On March 1, 2026, ULP-A punched in for her shift at 6:00 a.m., and punched out at 5:45 p.m. On March 2, 2026, ULP-A punched in for her shift at 6:00 a.m., and punched out at 1:00 p.m. R1's medication administration record (MAR) indicated ULP-A documented administering scheduled medications at 8:00 a.m. and 2:00 p.m. on February 21, 2026, the day of the incident, on February 23, 2026, the day RNDON-D was notified of the incident, and on February 27, 2026. R1's service delivery of care record indicated ULP-A continued to provide care and services to R1 the day the incident occurred on February 21, 2026, February 22, 2026, February 23, 2026, and February 27, 2026. Services ULP-A provided included dressing assistance, mobility assistance, physical assistance with toileting, pericare/incontinence care, and transfer assistance. A disciplinary form dated March 3, 2026, indicated ULP-A was terminated for the witnessed abuse incident on February 21, 2026. On April 1, 2026, at 9:48 a.m. during an entrance conference with facility leadership including RNDON-D, and Executive Director (ED)-C. Leadership stated ULP-A witnessed the incident and immediately reported the incident. Leadership stated they did not recall the timeline for ULP-A's report till when the investigation was completed. Leadership stated ULP-A wrote a	0 630		

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0 630	Continued From page 5 complaint and brought it to his attention immediately. He could not recall the exact timeline for when they were made aware of the incident but it was either the day of or the day after the incident occurred. Leadership denied having completed any post incident staff education following the incident prior to the investigator being onsite. On April 1, 2026, at 9:07 a.m., ULP-B stated she observed R1 bent over in his bed while ULP-B provided incontinence care. ULP-B stated she was shocked when ULP-A slapped R1 on his naked buttocks then giggled and said, "I just could not help myself". ULP-B stated she reported the incident immediately and was instructed to fill out a complaint form. ULP-B stated she received no education following the incident and ULP-A remained working with R1 as usual after she reported witnessing the abuse incident. On April 6, 2026, at 1:17 p.m., ULP-A stated she and R1 had a very close friendly relationship and they often joked around with one another. ULP-A stated R1 had made jokes about her breasts in the past and made a comment the day of the incident while R1 was naked, bent over in his bed to which she responded to by lightly slapping his buttocks. ULP-A denied any sexual or harmful intentions toward R1. She stated she immediately realized she had made a mistake, and should not have slapped R1. ULP-A stated she was not aware of any concerns about the incident and she continued to work with R1 and other residents as usual until she was terminated. On April 6, 2026, at 4:23 p.m., during email communication RNDON-D indicated the licensee's Vulnerable Adult policy and procedure	0 630		

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0 630	Continued From page 6 was not followed. RNDON-D indicated ULP-A should have been removed from the schedule until an investigation was completed. RNDON-D indicated ULP-A filled out a complaint form but failed to report the incident to leadership so action could be taken. RNDON-D indicated nursing was not notified until February 23, 2026, and at that time it was unclear what interventions were put into place to ensure R1 and other resident's safety. RNDON-D denied being aware of the incident prior to March 3, 2026 (despite documenting she was made aware of the incident on February 23, 2026). RNDON-D indicated an error was made when documenting the dates on the incident report. The dates documented on the incident report, progress notes, and complaint form aligned indicating RNDON-D's documentation in the resident record was accurate. TIME PERIOD TO CORRECT: Seven (7) days	0 630		
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. 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. Findings include: The Minnesota Department of Health (MDH)	02360		

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02360	Continued From page 7 issued a determination maltreatment occurred, an individual person was responsible for the maltreatment, in connection with incidents which occurred at the facility.	02360		