

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** HL295562123M

**Date Concluded:** July 29, 2025

**Compliance #:** HL295563670C

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

### **Investigated:**

The Waters of Plymouth

11305 Highway 55

Plymouth, MN 55441

Hennepin County

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

**Evaluator's Name:** Lena Gangestad, 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) emotionally abused the resident during an interaction involving her adult massager device.

### **Investigative Findings and Conclusion:**

The Minnesota Department of Health determined abuse was substantiated. The AP was responsible for the maltreatment. The AP approached the resident regarding a personal adult massager device located in a private drawer by her nightstand. The AP commented someone had said he would be willing to "help her out" because she was lonely. A handwritten note indicated the resident should use the AP for her sexual needs appeared to be similar to the AP's handwriting compared to his training records.

The investigator conducted interviews with facility staff members, including administrative staff, and unlicensed staff. The investigation included review of the resident's records, internal

investigation documentation, incident reports, personnel files, staff schedules, policies, and procedures.

The resident resided in an assisted living facility. The resident's diagnoses coronary atherosclerosis. The resident's service plan included assist with weekly housekeeping.

The resident's individual abuse prevention plan (IAPP) indicated the resident was oriented to person, place and time and no deficits with communication. The IAPP indicated the resident was able to recognize and report abuse.

A facility internal investigation indicated the AP, a housekeeper, approached the resident regarding her adult massager device located in a private drawer by her nightstand and made a comment someone was in her apartment the day prior while the resident was away. The AP said the unknown person said he would be willing to help her out because she (the resident) was lonely. The AP told the resident she was being stalked. Later that same evening at 11:30 p.m., the resident found a handwritten note inside a zippered pouch in her nightstand drawer. The note read: "Use your housekeeper instead of this tiny thing. I know your secret... He will make you feel better. He will come in every Thursday for you. I do not work here but I know you need {AP's name}. Don't be afraid to ask him." The facility management staff changed the resident's apartment locks for only the nurse and manager to have access. The internal investigation indicated the note compared with the AP's handwriting on his training records appeared to match. The AP's interview with facility management indicated he confirmed the conversation of with the resident regarding the unknown person, what was said and finding her personal adult massager device.

Comparison of the handwritten note and the AP's written training tests showed there was a unique letter "f" and "y" used in both the handwritten note and the AP's training records. The penmanship of both appeared similar.

During an interview, the resident stated the AP cleaned her apartment every Thursday. She typically remained in the room while staff cleaned but had been away at an appointment during his most recent visit. She described their interactions as generally friendly and limited to cleaning-related topics. However, during their last conversation, the AP told her he had seen a woman leaving her room who informed him the resident had an adult toy in her bedroom drawer. The resident reported feeling nervous but tried to deflect by laughing and walking away. Later that day, she recalled the conversation and checked the drawer where she kept her adult massager, stored in a zippered pouch. Upon opening it, she found the handwritten note. She reported feeling "freaked out" and stated, besides the AP, the only other person who entered her room was the nurse who administered medication at night, and she was always present during those visits. The resident said she did not know who left the note but found it alarming it referenced the AP and implied he would "take care of her" if she was lonely.

During an interview, the AP said he worked as a housekeeper and cleaned the resident's room once a week. He stated he had seen a woman with red hair, dressed in blue scrubs, sitting on a staircase. He stated he had never seen her before and did not know her name, as her name tag was covered. According to the AP, the woman told him she knew the resident and the resident possessed an item not allowed in the building. The AP stated he then approached the resident to inform her of what he had been told. He denied any knowledge of the note found in the resident's pouch and claimed he did not write it.

During an interview, the facility manager stated the resident had reported the incident to her. She placed the AP on administrative leave and initiated an internal investigation. The manager compared the handwriting on the note to the AP's handwriting on training documents and concluded it was a match. She also confirmed no one matching the AP's description of the woman had entered the building via camera footage. During her interview with the AP, the manager reported he denied writing the note and was informed it was inappropriate to tell a resident he "knew her secret."

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:

(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:** Yes.

**Alleged Perpetrator interviewed:** Yes.

**Action taken by facility:**

The facility did an internal investigation and the AP no longer works at 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 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 Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>29556</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/15/2025</b>
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NAME OF PROVIDER OR SUPPLIER  <b>THE WATERS OF PLYMOUTH</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>11305 HIGHWAY 55 PLYMOUTH, MN 55441</b>
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(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
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0 000	<p><b>Initial Comments</b></p> <p>*****ATTENTION*****</p> <p><b>ASSISTED LIVING PROVIDER CORRECTION ORDER</b></p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation.</p> <p>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.</p> <p><b>INITIAL COMMENTS:</b></p> <p><b>HL295562123M/HL295563670C</b></p> <p>On May 15, 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 115 residents receiving services under the provider's Assisted Living with Dementia Care license.</p> <p>The following correction order is issued for HL295562123M/HL295563670C, tag identification 2360.</p>	0 000	<p>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.</p> <p><b>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.</b></p> <p><b>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</b></p> <p><b>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.</b></p>	
02360	<p><b>144G.91 Subd. 8 Freedom from maltreatment</b></p> <p>Residents have the right to be free from physical,</p>	02360		

Minnesota Department of Health  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>29556</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/15/2025</b>
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02360	<p>Continued From page 1</p> <p>sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act.</p> <p>This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident reviewed (R1) was free from maltreatment.</p> <p>Findings include:</p> <p>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.</p>	02360	No plan of correction is required for this tag.	