Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL302468422M
Compliance #: HL302461080C

Date Concluded: May 5, 2026

Name, Address, and County of Licensee Investigated:
Regina Assisted Living
1008 1st Avenue
Hastings, MN 55033
Dakota County

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

Evaluator's Name: Willette Shafer, RN
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 the resident when the AP kissed the resident on her lips, rubbed his genital area against her, and made sexually inappropriate hand gestures and comments.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was inconclusive. While kissing does not meet the definition of sexual contact, the resident and the AP reported the same story that they were dancing, close enough to touch bodies. Both the resident and AP reported the AP kissed her on the cheek. The resident and the AP had conflicting stories about the abruptness of the AP leaving the resident's apartment. The resident said the AP kissed her on the lips. The AP reported the resident kissed him on the lips that made him uncomfortable, he pulled away and left her apartment immediately. The resident reported the AP rubbed his genitals against her while dancing closely and made a comment about having an erection. The resident said he adjusted his pants and left the room.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator interviewed the resident and alleged perpetrator. The investigation included review of the resident's record, facility internal investigation, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator toured the facility and observed pastoral services provided to residents.

The resident resided in an assisted living facility. The resident's diagnoses included Alzheimer's disease with early onset, psychotic disturbances, anxiety, and depression. The resident's service plan included assistance with medication management, behavioral management, activity reminders, and housekeeping. The resident's assessment was updated after the incident and indicated the resident required same gender staff or two-person assist during "high-risk" cares or while providing services.

The resident's progress notes indicated the resident reported an interaction with the AP that made her uncomfortable. She reported the AP was a "nice person" and she did not want him to "get in trouble." She reported she did not understand why the AP met with her in her apartment.

The facility's internal investigation indicated the resident reported the AP completed an initial pastoral care visit with the resident in her apartment. During the visit, the resident and AP danced. The resident reported the AP kissed her on both cheeks and on the lips. She felt the AP's genital area rubbing against her while they danced. The resident reported she observed the AP had an erection and he was "fiddling" with himself. As the AP left he said, "you gave me a boner." The AP denied inappropriate sexual behavior during the visit. He reported he initially met with the resident in the lobby. She was upset about living in a facility and paranoid about getting in trouble for talking about it. The AP offered to meet with her in her apartment for privacy. He reported he often visits with residents in their apartments. During their visit, the resident said she enjoyed dancing. The AP offered to dance with her. While dancing the resident kissed him on the cheek. He kissed her back on the cheek. Then the resident kissed him on the lips, and he pulled away from her. He felt uncomfortable and told her he needed to leave. He reported elderly residents had kissed him in the past, but he believed the resident misinterpreted their dancing and was flirting with him. He reported kissing on the cheek was a traditional greeting in his culture but when the resident kissed him on the lips it felt "flirty," so he ended the visit. The AP denied he had an erection and denied he commented about having an erection to the resident. He admitted their bodies were touching while dancing. He reported physical touch including hand holding, and human touch was a part of chaplain training.

During an interview, the resident said the AP came to her room to counsel her. She told him she liked to dance, and he asked her to dance. She declined the dance but said the AP asked her several times until she agreed to dance. She said while dancing they held each other's hand, and their other hand was on the waist area. Their bodies were touching during the dance, and she could feel the AP had an erection. After their dance she said he was adjusting his pants in

the genital area and commented he had an erection. The resident did not mention kissing during the interview as originally reported.

During an interview, the AP said he provided spiritual and emotional support to residents. He met with the resident in the lobby, and she was upset about being at the facility. He offered to visit with her in private. He preferred to visit resident's in their apartments as it gave him an opportunity to observe their interests, family pictures, and often sparked conversations. During their visit, the resident reported she used to dance, and dancing gave her joy. The AP offered to dance with the resident. He said he followed the resident's lead during the dance because he did not know how to dance. During the dance the resident kissed him on the cheek, and he kissed her back on the cheek. He said in his culture people often kiss on the cheek as a greeting. Then the resident kissed him on the lips which made him uncomfortable. He backed away from the resident and told her he had to leave. He denied he said anything related to an erection. He said he had never been accused of inappropriate sexual behavior in the past.

During an interview, manager-1 said an internal investigation was completed. The resident and the AP were interviewed along with several other residents the AP visited with before the incident. The other residents interviewed reported they liked the AP and had positive things to say about him. Facility staff members reported having a positive working relationship with the AP. The resident who reported the allegation gave conflicting information at times. The AP completed additional training and continued to work at the facility.

During an interview, the AP's supervisor said she completed all the required training with the AP when he started. She acknowledged that physical touch was incorporated in standard spiritual training but not kissing. In the AP's culture, kissing was a standard greeting, but additional education was provided to the AP after the incident. The AP began working at the facility two months before the incident. He had previously worked in a different state. She denied she contacted the AP's references before she hired him and was unaware if human resources checked his references. The AP previously worked as a missionary in different countries.

During an interview, manager-2 said the resident was recently diagnosed with Alzheimer's disease, but she was very independent and able to leave the facility as desired. She described the resident as fun-loving and flirty with men at times. Manager-2 described the AP as soft spoken, kind, and very spiritual.

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, declined.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility conducted an internal investigation and provided additional training for the AP.

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
	30246	A. BUILDING: _____ B. WING _____	C 04/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGINA ASSISTED LIVING	1008 1ST STREET WEST HASTINGS, MN 55033

(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 April 10, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL302461080C/#HL302468422M and #HL302466860C/#HL302461800M. No correction orders are issued.	0 000		