Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL306802922M
Compliance #: HL306805387C

Date Concluded: July 7, 2025

Name, Address, and County of Licensee Investigated:
Aspen Grove Assisted Living
504 Iron Drive
Chisholm, MN 55719
St. Louis County

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

Evaluator's Name: Barbara Axness, RN
Special Investigator

Finding: Not Substantiated

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 resident when she performed oral sex on the resident.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was not substantiated. The AP and the resident denied the incident occurred.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement. The investigation included review of the resident record, facility internal investigation, facility incident reports, personnel files, staff schedules, and related facility policy and procedures.

The resident resided in an assisted living facility. The resident's diagnoses included traumatic brain injury (TBI) and right hemiplegia. The resident's service plan included assistance with

activities of daily living and medication administration. The resident's assessment indicated the resident had impulsive behaviors due to his TBI and had a history of making inappropriate sexual comments to female staff.

Complaint documents indicated an incident occurred where an unlicensed personnel member (ULP) caught another ULP/alleged perpetrator (AP) giving the resident oral sex and the resident was noted to be saying he didn't want the AP to do that when the other ULP caught them. The complaint document indicated the AP was terminated for the incident but was rehired a few months later.

The facility's internal investigation indicated they were not aware of any allegations until the police showed up to investigate a report of sexual abuse. Facility management interviewed staff involved and the resident. The AP was "upset that anyone would accuse her of inappropriate behaviors" and "that would never happen." The AP felt the allegation originated from another staff member who was trying to get her in trouble. Facility management interviewed the other ULP who stated she had some personal issues with the AP.

The AP's employee record was reviewed and there were no gaps in her employment at the facility. The AP did not have any disciplinary actions and had a completed background study.

During an interview, a ULP stated she had not seen the AP perform oral sex on the resident, but she walked into the resident's room one day and the AP's hand was underneath his blanket and the resident was smiling. The ULP stated she asked the AP and the resident what was going on and they both replied "nothing", and the AP walked out of the room. The ULP stated she didn't think nothing was going on and was concerned the AP had been stroking the resident's penis.

During an interview, management stated they hadn't heard any rumors or any allegations at the facility and they were surprised when the police showed up to investigate the allegation. Management stated they met with the AP and the other ULP and after their investigation, it was determined the other ULP made up the allegations against the AP. Management stated the AP was not terminated as alleged but had taken some time off and reduced her hours.

During an interview, the police department stated the case was closed and no further action would be taken as it was determined another staff member had made up the allegations against the AP.

During an interview, the resident stated he had never had any kind of relationship with any staff member and never engaged in anything inappropriate with the AP.

During an interview, the AP stated the allegations were not true and she had worked in long term care for a long time and would never do something like that. The AP stated another ULP made up the allegations against her to try get her in trouble.

In conclusion, the Minnesota Department of Health determined abuse was not substantiated.

“Not Substantiated” means:
An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment 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: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
No action required.

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
	30680	A. BUILDING: _____ B. WING _____	C 06/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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 June 10, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL306802922M/ #HL306805387C. No correction orders are issued.	0 000		