State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL334268202M
Compliance #: HL334269242C

Date Concluded: March 3, 2026

Name, Address, and County of Licensee Investigated:
Harmony View Assisted Living
1420 2nd street North
Sauk Rapids, MN 56379
Benton County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Erin Johnson-Crosby, 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)/unlicensed facility staff abused the resident when the AP engaged in a sexual relationship with the resident.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was substantiated. The AP was responsible for the maltreatment. Text messages and video confirmed the AP engaged in a sexual relationship with the resident while the AP was an employee at the facility.

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, text/video messages, and related facility policy and procedures. The investigation also included an onsite visit with observations of staff and resident interactions.

The resident resided in an assisted living facility. The resident's diagnoses included traumatic brain injury, bipolar disorder, depression, personality disorders and post-traumatic stress disorder. The resident's service plan included assistance with glucose monitoring, medication set-up and behavior

management. The resident's assessment indicated the resident was independent with transfers, bed mobility and walked with a cane. The resident was cognitively intact but at risk for abuse related to a history of traumatic brain injury.

Documentation reviewed indicated the AP began a sexual relationship with the resident when the AP was employed by the facility.

Hundreds of text messages reviewed between the AP and the resident, included numerous sexual text messages including sexual videos sent by the AP to the resident. The videos sent included identifying images of the AP. The text messages indicated the AP and the resident had sexual intercourse. The text messages also included where they should meet so facility staff did not notice the AP with the resident. The number on the text messages sent to the resident matched the number provided by the AP to the investigator for interview.

The AP's employee record included a signed job description and completed vulnerable adult training prior to working at the facility.

During an interview, an unlicensed personnel stated after the AP quit working for the facility, the AP told her about the sexual relationship with the resident.

During an interview, the resident stated the relationship began when the AP worked in the kitchen. At first, they exchanged flirtatious comments and glances. One day, the resident was in the shower and heard someone come into his apartment. He came out of the shower in a towel and the AP was standing there, grabbed his genitals and kissed him. The resident reported that over the next few weeks, the relationship progressed quickly. While the AP worked, the resident would touch the APs hand, and the AP would kiss him. They would meet in the elevator or hallways and ensure no other staff or residents saw their interactions with each other. The AP and resident began texting each other over a period of days which included where the resident should meet the AP so the AP could pick the resident up in her car without facility staff noticing. Over a period of three to four days the resident stated he and the AP had sex "repeatedly, excessively and as much as they could." The resident stated the other facility staff were not aware of the incident.

During an interview, the AP stated that she and the resident were friends and hung out with each other outside of work. The AP stated that they would go for car rides together and a couple of times the resident went to her house. The AP confirmed she and the resident text back and forth but denied the videos or text messages were sexual in nature and did not know how the resident would have obtained the videos or text messages. The AP stated she thought the resident was retaliating against her. The AP did not find anything wrong with hanging out with the resident outside of work.

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: No, attempts to contact were unsuccessful.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
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.

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
Benton County Attorney
Sauk Rapids, City Attorney
Sauk Rapids, Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33426	A. BUILDING: _____ B. WING _____	C 12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY VIEW ASSISTED LIVING	1420 2ND STREET NORTH SAUK RAPIDS, MN 56379

(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: #HL334266484C/#HL334267002M #HL334269242C/#HL334268202M On December 11, 2025, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction order is issued. At the time of the complaint investigation, there were 17 residents receiving services under the Assisted Living license. The following correction order is issued for #HL334269242C/#HL334268202M 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: The facility failed to ensure one of one resident(s) reviewed (R1) was free from maltreatment. Findings include: 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.	02360	No plan of correction is required for this tag.	