Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL359034922M
Compliance #: HL359031144C

Date Concluded: October 17, 2025

Name, Address, and County of Licensee Investigated:
Metro Assisted Living
7663 Jackson Street Northeast
Fridley MN, 55432
Anoka County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Kris Detsch, 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), who was an unidentified staff member, sexually abused the resident when he had sexual contact with her.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined sexual abuse was not substantiated. Medical records indicated the resident said the incident occurred prior to the AP's employment at the facility. Additional evidence indicated the resident made this allegation during a meeting with the facility leadership as they were terminating her services.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted case workers and mental health providers. The investigation included review of the resident records, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator toured the facility and observed their staffing levels, and documentation systems.

The resident resided in an assisted living facility. The resident's diagnoses included borderline personality disorder (unstable mood disorder). The service plan included assistance with behavior management, housekeeping, and medication administration. The resident's nursing assessment indicated she had anxiety, and agitation. The nursing assessment indicated she was independent in her daily cares, including mobility.

Medical records indicated the resident called her medical providers and told them the AP took advantage of in a sexual manner. The records contained conflicting accounts where the encounter occurred.

During an interview, a manger said the resident admitted into the facility after she discharged from a treatment center (in-patient facility for residents with substance abuse disorders). The manger said upon admission into the facility, the resident left and returned intoxicated. The manager said this behavior continued and the resident was increasingly aggressive with staff and other residents. The manager said the resident also used street drugs and was often "high." The manger said the facility started the process of terminating her services. The manager said the facility had a meeting with the resident, and her care team when she told them she had a sexual encounter with a staff member. The manager said initially she told them it was a different staff member, then she said it was the AP. The manger said the resident was very vague and did not provide any further details. The manager said the AP worked at a different location, and was only at the facility one day for training. The manager said other staff were in the facility with the AP on this day and no there were no concerns about his behavior. The manager said the resident abruptly discharged from the facility. The manger said a case worker told him the resident went to a "sober" house (treatment facility).

During an interview, the AP said he was only at the facility one day for training and other staff were present during this time. The AP denied ever touching the resident sexually.

Medical records indicated the resident reported the initial allegation to her mental health providers approximately one month after she said the incident occurred. The records indicated the resident told them the date the incident occurred, but this date was prior to the AP being at the facility.

Service delivery records lacked indication the AP was providing services at the facility while the resident lived there.

The resident's medical records indicated she had intrusive memories from sexual traumas throughout her life and an extensive history of drug and alcohol dependency.

In conclusion, the Minnesota Department of Health determined sexual 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;
(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; and
(4) use of any aversive or deprivation procedures for persons with developmental disabilities or related conditions not authorized under section 245.825.
(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: No. Whereabouts unknown.
Family/Responsible Party interviewed: No. Not Applicable.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility coordinated care with the resident’s advocate (ombudsman).

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
	35903	A. BUILDING: _____ B. WING _____	C 09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO ASSISTED LIVING	7663 JACKSON STREET NE FRIDLEY, MN 55432

(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 September 4, 2025, the Minnesota Department of Health initiated an investigation of complaint HL359031144C/HL359034922M. No correction orders are issued.	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.	