Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL377132803M
Compliance #: HL377135009C

Date Concluded: September 16, 2025

Name, Address, and County of Licensee Investigated:

Dis-Generation Group Inc
9032 Prestwick Parkway
Brooklyn Park, MN 55443
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Lisa Coil, RN, BSN
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), a facility staff member, sexually abused the resident when the AP raped her.

Investigative Findings and Conclusion: The Minnesota Department of Health determined abuse was inconclusive. There was no physical evidence the AP sexually abused the resident. Due to conflicting accounts of the incident, it could not be determined whether sexual abuse did or did not occur.

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, hospital records, facility internal investigation, personnel files, staff schedules, and law enforcement report.

The resident resided in an assisted living facility. The resident's diagnoses included post-traumatic stress disorder, traumatic brain injury, major depressive disorder, and anxiety.

The resident's service plan included assistance with medication management and safety checks. The resident's assessment indicated the resident was alert, orientated, verbally abusive, manipulative and exploited others. The assessment further indicated the resident was verbally and physically aggressive, socially and sexually inappropriate.

An incident report indicated the resident had been out of the facility earlier one evening and when she returned, she started shouting while demanding a lighter so she could smoke. The resident told staff she was leaving the facility to get a lighter. The incident report indicated the resident returned to the facility with her boyfriend, they knocked on the door and when staff opened the door the boyfriend immediately ran away.

The same incident report indicated a short time after returning to the facility the second time, the resident was in her room screaming and crying but when staff asked her if she was okay, she said leave me alone. The report further indicated the resident did eventually shout out for help. Staff went to help the resident, found her on the toilet, and assisted her to bed.

The same incident report indicated the resident eventually came out of her room and called 911 from the home phone. The police and paramedics showed up to the facility without the staff's knowledge of them being contacted. The resident was taken to the hospital for evaluation per her request.

The law enforcement's first officer's report indicated they were dispatched at 12:15 a.m. one morning to a sex crime. The first officer interviewed the resident. The report indicated the resident told the officer the AP had raped her approximately 10 to 15 minutes prior. The resident told the officer she had went to a bar, where she had two alcoholic beverages, and was picked up by the AP at midnight. The resident told the officer when they arrived at the facility, she went to her room, the AP followed her, the AP pulled down her panties, started sucking on her genital area, and fondled her body. The resident told the officer the AP stopped when she said she was going to throw up. The report indicated the officer was assisting the resident in finding her panties but was unable to locate them where the resident said they were, or anywhere in the room.

The law enforcement second officers report indicated they were dispatched at 12:53 a.m. one morning to sex crime. The second officer interview the AP regarding the incident. The AP told the officer the resident was not at the facility when his night shift started but she arrived about 30 minutes later. The AP told the officer the resident was asking for a lighter, but the AP did not have one, so the resident left the facility and returned about midnight. The AP told the officer when he opened the door for the resident, there was a male at the door with her, the resident came in and he does not know where the male went or if the male was in a vehicle. The AP told the officer about ten minutes later the resident was screaming in the bathroom, asking for help, so he went and helped her walk from the toilet to her bed. The AP told the officer the resident started screaming at him and telling him to get out of her room.

The first emergency department (ED) report indicated the resident was brought in due to a sexual assault with no penetration. The resident told ED staff she drank three tequila-based drinks and a beer and had complaints of nausea and abdominal pain, no other complaints. The report indicated she did not want any medical test done and was just there because she was told she had to go for a sexual assault exam. The case was discussed with the sexual assault team, and they said there was nothing to do since there was no penetration. The report indicated there was no reason for examination of the genitalia. The report further indicated placement resources were offered to the resident, and she declined. The resident told ED staff she was comfortable going back to the facility. The resident discharged back to the facility.

A second ED report, from a different location about one and a half days later, indicated the resident had been out to get her hair done, stopped at the bar, and had a few shots of Patron. The resident told ED staff when she got back to the facility one of the workers helped her walk up to her room and he raped her. The resident told ED staff the AP had bit her [genital area]. The report indicated the resident had four curvilinear breaks in her skin in the genital area. The report indicated internal genital exam was not done because the resident said there was no penetration. The report indicated the resident was admitted to the behavioral health unit.

The facility was equipped with video surveillance. Video footage showed the resident arriving at the facility around midnight one night in a vehicle driven by an unknown male. The resident was heard talking and laughing during the footage. The unknown male assisted the resident to the front door of the facility and the male returned to the vehicle.

Once inside video footage showed the resident walk up the stairs, enter her room, come back to the stairs while saying to the AP “what is your f-----g name?” The resident continues to walk back down the stair to the staff desk and says, “I need a hug right now” and the video footage ends. The next video clip, within one minute shows the resident turning away from the staff desk as the AP is getting up from his chair. The resident goes up the stairs and motions for the AP to go down, which he does.

Ten minutes later, the video clip shows the AP quietly going up the stairs while looking down the hall and listening for the resident. The AP asks the resident if she needs assistance, the resident declines. Two minutes later the AP hears the resident hollering for help and goes to assist. According to the video clips, the AP is in the resident’s room and/or bathroom for four and a half minutes with the resident. During that time, talking, moaning, groaning, light banging/shuffling noises were heard through the audio on the video clip. The AP does not enter the resident’s room the rest of the shift.

During an interview, the resident stated she had stopped at a restaurant/bar one evening and had two or three shots of Petrol. The resident stated she did not drink often, and Petrol was a new drink for her. The resident stated the bartender called a taxicab who brought her back to the facility. The resident stated the taxicab driver did not get out of car when they arrived at the facility. The resident walked to the door, knocked, the AP opened door, and the AP said let me

help you upstairs. The resident stated the AP walked her to her room, started tearing off her clothes, and the last thing she remembered was the AP unzipping his pants. The resident felt she was going in and out of consciousness and stated she did not know if the AP drugged her. The resident stated she thought she was “pretty tipsy” because she blacked out and fell asleep. When the resident woke up, she stated she could not find her cell phone, so she went and used the house phone to call 911 and reported a rape.

During the same resident interview, the resident stated during the first ED visit a quick [sexual assault] kit was completed and the ED staff saw bite marks on her [genital] area. The resident stated she was sent back to the facility and could not understand why she would be sent back to a place she was just violently raped at. The resident stated she called 911 a second time shortly after returning to the facility to take her back to a different ED. She stated that ED did a full [sexual assault] kit, including a swab. The resident stated she was admitted to inpatient following her ED visit.

During an interview, the AP stated the residents had left the facility to get a lighter and later return accompanied by a male who left as soon as the AP opened the door. Shortly after returning, the resident was in her room screaming and crying. The AP stated he asked the resident what was wrong, and she said to leave her alone. The AP stated the resident was then yelling “help me, help me” so he went to assist her. The AP stated he found her in the bathroom “lifeless,” and assisted her to bed because she could not walk by herself. The AP stated a little while later he saw the resident on the house phone and thought she was calling the person who dropped her off earlier. The AP stated she returned to her room after using the phone and began screaming and crying, so he offered her an as needed medication. The AP stated next the police were knocking at the door and said the resident had called 911. The AP stated the sounds heard in the video clips were her moaning because she was drunk and not conscious. The AP denied having any sexual contact with the resident.

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, attempted but did not reach.
Alleged Perpetrator interviewed: Yes.

Action taken by facility: The facility investigated the incident.

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
	37713	A. BUILDING: _____ B. WING _____	C 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIS-GENERATION GROUP INC	9032 PRESTWICK PARKWAY BROOKLYN CENTER, MN 55443

(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 12, 2025, the Minnesota Department of Health initiated an investigation of complaint HL377136027C/HL377133182M and HL377135009C/HL377132803M. No correction orders are issued.	0 000		