

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL353103568M
Compliance #: HL353103107C

Date Concluded: September 14, 2026

Name, Address, and County of Licensee

Investigated:

Unique Homes LLC
4922 N Newton Ave
Minneapolis, MN 55430
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name:

Lacey Eggersdorfer, RN, Special Investigator

Finding: Substantiated, facility 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 facility neglected resident #1 and resident #2 when the facility failed to provide adequate supervision, leading to resident #1 sexually harassing resident #2 on two separate occasions.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined neglect was substantiated. Facility staff failed to provide supervision to resident #1 when he had inappropriate behaviors with resident #2 or when he would leave the facility for multiple days without staff knowing his location. Facility staff were aware of resident #1's inappropriate behaviors with resident #2 and wandering and failed to assess and implement interventions to ensure the safety of resident #1 and resident #2.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted case management. The investigation included review of the resident records, facility internal investigation, facility

incident reports, personnel files, staff schedules, law enforcement report, related facility policy and procedures.

Resident #1 resided in an assisted living facility. Resident #1's diagnoses included schizophrenia, bipolar disorder, and traumatic brain injury. His service plan included medication administration and safety checks. Resident #1's assessment indicated he was alert and oriented and needed behavior management for wandering and alcohol abuse. Resident #1's assessment also indicated he was at risk for abusing other vulnerable adults. Resident #1's behavior management plan was updated to include inappropriate sexual behaviors and alcohol consumption, however, the facility failed to implement or enforce their new interventions for behaviors, and no new interventions were implemented to prevent future incidents.

Resident #2 resided in an assisted living facility. Resident #2's diagnoses included anxiety, psychosis, and traumatic brain injury. Resident 2's service plan included assistance with taking medications and management of anxiety and depression. Resident 2's assessment indicated she was alert and oriented and was at risk of abuse from others.

Law enforcement reports indicated resident #2 was being sexually harassed by resident #1. Resident #1 solicited oral sex from resident #2 and slapped her in the butt multiple times without consent. Resident #2 had informed facility staff about the sexual incidents and facility staff had not intervened. Law enforcement reports also indicated resident #1 retaliated and threatened resident #2 after she disclosed the incidents to the facility staff.

Facility records indicated an internal investigation was completed after resident #1 was inappropriate with resident #2 twice. The internal investigation indicated the first incident was disclosed by resident #2 about a week after it occurred. During that incident, resident #1 was intoxicated and entered resident 2's room, solicited oral sex from resident #2, and exposed his genitalia. Resident #2 requested resident #1 to leave her room and he complied. Resident #1 did not recall entering resident #2's room or soliciting oral sex. Approximately two months later resident #1 walked closely behind resident #2 when resident #2 bent over to pick up an item in the kitchen. Resident #2 expressed discomfort with resident #1's actions, and resident #1 apologized. Facility records indicated resident #1 touched resident #2 inappropriately during the incident but lacked any details.

Progress notes indicated resident #1 was frequently intoxicated while in other resident's rooms, slept in other resident rooms, wandered from the facility, and at times was so intoxicated he required staff assistance to stand. Staff did not redirect resident #1 or notify licensed staff of behaviors. Progress notes lacked acknowledgement of resident #1 touching resident #2 inappropriately twice. Additionally, progress notes indicated resident #1 left the facility for days at a time. Over the course of three months, resident #1 was missing from the facility for a total of thirty days and facility staff were unaware of his location. One month in that time frame resident #1 was missing for sixteen total days. Progress notes lacked indication that facility staff

notified licensed staff, looked for resident #1, or notified law enforcement that resident #1 was missing.

Service delivery record for resident #1 indicated on the days he was absent from the facility he was not administered medications or monitored for wandering behaviors.

Progress notes for resident #2 at the time of resident #1 exposing his genitalia to her indicated she was unable to sleep and disclosed fear and anxiety due to an incident that occurred with another resident the night before. Unlicensed staff did not notify licensed staff that resident #2 had an incident with another resident. Progress notes lacked documentation of resident #1's sexual advances or contact with resident #2.

Training records indicated there was no training completed following the second incident between resident #1 and resident #2.

During an interview, management stated they were aware that resident #1 had inappropriate behaviors when he was intoxicated and acknowledged that he would required more assistance from staff. When resident #1 was intoxicated staff were instructed to redirect him to his room. An unlicensed staff member contacted management after resident #2 disclosed being solicited for oral sex by resident #1. Staff were instructed to encourage residents to be in communal areas and be aware of resident #1's whereabouts at all times. Those intervention were unsuccessful. Management believed the second incident of resident #1 touching resident #2 in the kitchen was accidental.

During an interview, an unlicensed staff #1 stated resident #1 was drunk in the kitchen when she overheard resident #2 say resident #1 smacked her butt. Resident #1 apologized to resident #2. Unlicensed staff #1 stated resident #1 had been inappropriate when he was drunk in the past, and she brushed off his behavior due to his intoxication. Unlicensed staff #1 also stated resident #1 was reported missing from the facility often due to him being absent for more than 24 hours frequently.

During an interview, licensed staff stated resident #1's behavior management plan was updated to include interventions for inappropriate sexual behaviors and alcohol use; however, licensed staff did not expect to be called every time resident #1 was drunk. Licensed staff stated she did not question resident #1 about inappropriate sexual behaviors, exposing his genitals to resident #2, or physical contact with resident #2. She did not ask resident #2 about resident #1's inappropriate sexual contact. She denied considering a substance use evaluation referral for resident #1. Licensed staff also stated she was unaware that resident #1 had been missing from the facility for sixteen total days the previous month.

During an interview, resident #1 stated he does not remember his actions when he is drunk. He denied facility staff had voiced concerns about his actions with other residents or that he spent

time in other resident rooms while intoxicated. Resident #1 stated he left the facility and would not tell staff where he was going. He denied licensed staff voiced concerns about his wandering from the facility for days at a time. Resident #1 stated he would get a ride back to the facility by police if he was stopped for engaging in illegal activity, or the hospital would arrange a ride. Resident #1 explained he did not have a cell phone to call facility staff.

During an interview, resident #2 stated during the first incident resident #1 entered her room and was drunk when he exposed his genitalia to her and began masturbating in front of her. She stated he tried to get under her dress and put his mouth on her genitals. Resident #2 told resident #1 to leave multiple times. She disclosed the incident to management a week later. Resident #2 stated during the second incident, resident #1 was drunk and smacked her on the butt. She told him he made her uncomfortable and reported the incident to facility staff immediately. Resident #2 also stated that resident #1 confronted her about reporting the incidents to facility management and was angry with her.

During an interview, a family member stated they have had concerns with the facility not supervising resident #1 before. She had advocated for resident #1 to receive more supervision, and the facility declined to do so.

In conclusion, the Minnesota Department of Health determined neglect 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.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17

“Neglect” means neglect by a caregiver or self-neglect.

(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:

(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and

(2) which is not the result of an accident or therapeutic conduct.

Vulnerable Adults interviewed: Yes

Family/Responsible Party interviewed: Family of resident #1; resident #2 requested the investigator not reach out to family regarding the investigation.

Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:

The facility updated behaviors of resident #1 to include sexual behaviors.

Action taken by the Minnesota Department of Health:

The responsible party will be notified of their right to appeal the maltreatment finding.

The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

<https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html>

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

You may also call 651-201-4200 to receive a copy via mail or email

cc:

The Office of Ombudsman for Long Term Care

The Office of Ombudsman for Mental Health and Developmental Disabilities

Hennepin County Attorney

Minneapolis City Attorney

Minneapolis Police Department

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35310	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/22/2026
NAME OF PROVIDER OR SUPPLIER UNIQUE HOMES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 4922 NEWTON AVENUE NORTH MINNEAPOLIS, MN 55430		
(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: #HL353103107C/#HL353103568M On July 22, 2026, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 4 residents receiving services under the provider's Assisted Living license. The following correction order is issued for #HL353103107C/#HL353103568M, tag identification 2360.	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		

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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0 000	Continued From page 1	0 000	ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
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. This MN Requirement is not met as evidenced by: The facility failed to ensure two of two resident(s) reviewed (R1 and R2) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360			