Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL338047283M
Compliance #: HL338046982C

Date Concluded: December 16, 2025

Name, Address, and County of Licensee Investigated:
Orchard Path
5400 157th Street West
Apple Valley, MN 55124
Dakota County

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

Evaluator's Name: Willette Shafer, 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 facility neglected resident-1 when the facility failed to supervise resident-1 and resident-2. Resident-2 physically assaulted resident-1 causing resident-1 to fall and injure her hip.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although resident-1 was found on the floor in the sunroom while resident-2 was also in the sunroom, the incident was unwitnessed. After the incident, resident-2 found staff and reported resident-1 was on the floor and needed help. Neither resident-1 nor resident-2 were able to report what happened as they both had memory impairment. Resdeint-2 had a history of aggressive behaviors, but the facility implemented numerous interventions to help manage these behaviors and keep other residents safe.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted resident-1's family member. The

investigation included review of resident-1 and resident-2's records, resident-1's death record, facility internal investigation, facility incident reports, surveillance footage of the hallway outside of the sunroom, staff schedules, and related facility policy and procedures. Also, the investigator toured the facility and observed resident supervision in the memory care area.

Resident-1 resided in an assisted living memory care unit. The resident's diagnoses included dementia, left sided weakness due to past stroke, and aphasia (difficulty speaking). The resident's service plan included assistance with bathing, grooming, meals, medication management, reminders, and housekeeping. Resident-1 was on hospice and was at risk for falls. She had a recent fall less than a week before the incident.

A progress note indicated resident-2 recently moved to the memory care area after increased confusion and memory concerns. Since moving to the memory care area, she began exhibiting some aggressive behaviors. The behaviors escalated from verbal threatening to physically pushing two different residents on two separate occasions. Residnet-2's primary care provider adjusted her medications to help manage resident-2's behaviors but then resident-2 began refusing her medications. After the second time resident-2 pushed a resident causing that resident to fall, the facility recommended resident-2 transfer to a psychiatric memory care unit where her behaviors could be managed more effectively. A referral was written to transfer resident-2 due to aggressive behaviors. In the meantime, the facility increased the frequency of resident-2's safety checks, redirect other residents away from resident-2, and redirect resident-2 as needed. A progress note written a couple days later indicated the psychiatric facility denied resident-2's admission based on insurance coverage. Resident-2 was transported to the hospital for inpatient psychiatric needs. The hospital sent the resident back to the facility a couple days later due to resident-2 not exhibiting any aggressive behaviors while at the hospital.

A progress note written a week after resident-2 returned from the hospital indicated resident-2 was "suspected" of pushing resident-1 in the sunroom causing resident-1 to fall and injure her hip.

Camera footage of the hallway leading into the sunroom showed resident-1 walking into the sunroom with her walker. A couple minutes later resident-2 walked into the sunroom with her walker. Twenty-five seconds later, resident-1's walker was observed slowly rolling out of the sunroom into the hallway. A few seconds later, resident-2 was observed exiting the sunroom and knocking on resident apartment doors in the hallways near the sunroom. When nobody answered the door, resident-2 was observed walking back down the hallway quickly.

A progress note indicated resident-2 reported resident-1 fell and needed help. Resident-1 and resident-2 were unable to voice further details of the incident due to cognition. After the suspected aggression against resident-1, the facility assigned a one-to-one staff member with resident-2. Resident-2's family was notified and agreed to take resident-2 home during the day and return her in the evening. Resident-2's family agreed to relocate her to a setting with

increased behavioral support. Resident-2's primary care provider reviewed medications and made more adjustments.

A progress note written a week later indicated resident-2's family hired a personal care attendant to provide one-to-one assistance during the day at the facility. The facility provided safety checks every two hours and would call 911 if resident-2 was physically aggressive and unable to redirect. Resident-2's primary care provider sent a referral for psychiatry to evaluate and treat.

During an interview, resident-1's family member said resident-2 was physically aggressive towards resident-1 before the alleged incident. She said resident-1 had a black eye once and they suspected she received the black eye from resident-2 as they were in the sunroom together around the time they noticed the injury. There were no witnesses to the alleged incident. Another time resident-2 pushed resident-1 in the dining room and caused resident-1 to fall resulting in some bruising. She said resident-2 should have been evicted, medicated, or restrained to ensure other residents were safe.

During an interview, a member of management, who was also a nurse, said resident-2 recently admitted to memory care due to increased confusion. Her behaviors began a few months after moving into memory care. The facility implemented several interventions to support resident-2 and keep other residents safe including medication adjustments, increased safety checks, redirection, and one-to-one staffing. The resident's primary care provider referred her to a psychiatric facility, but resident-2 was denied due to insurance issues. Resident-2 was sent to the hospital and admitted to their psychiatric unit but returned two days later as she never exhibited any behaviors. The hospital also adjusted her medications.

During an interview, a nurse said resident-2 recently became verbally threatening towards staff and others. Her behaviors escalated and she began running her walker into staff. She had a couple incidents of physical aggression towards other residents, usually when others were in her space or attempted to enter her apartment. Several interventions were implemented to keep resident-2 and others safe. The nurse trained facility staff on resident-2's care plan. Resident-2's care plan included specific instructions on how to manage her behaviors. The nurse updated the provider and family any time resident-2 exhibited an aggressive behavior. Resident-2's primary care provider adjusted her medications several times. At one point, resident-2's family was taking her home during the day and returning her in the evening. The family also hired an outside care attendant to monitor resident-2 until she was discharged to a geriatric psychiatric facility.

Resident-2's medical record included multiple interventions implemented at various times to support resident-2, alleviate behaviors, and ensure safety of others. The documented interventions included several medication adjustments reviewed and made by different providers, increased safety checks, a 911 protocol, redirection, one-to-one staff assigned,

outside service support from various entities, referrals to outside agencies, and once approved and accepted an extended leave of absence for behavior support.

In conclusion, the Minnesota Department of Health determined neglect 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.

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 Adult interviewed: No, deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
The facility implemented numerous interventions to support resident-2 and keep other residents safe. The facility completed incident reports, internal investigations, and educated staff on the resident’s care plan.

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
	33804	A. BUILDING: _____ B. WING _____	C 11/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ORCHARD PATH	5400 157TH STREET WEST APPLE VALLEY, MN 55124

(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: HL338047283M/HL338046982C HL338047443M/HL338047343C On November 13, 2025, 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 71 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for HL338047443M/HL338047343C, tag identification 2360. No correction orders are issued for HL338047283M/HL338046982C.	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.	
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical,	02360		

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02360	Continued From page 1 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 one of one resident 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		