Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL347168842M
Compliance #: HL347166641C

Date Concluded: April 21, 2025

Name, Address, and County of Licensee Investigated:
Orchards of Minnetonka
10955 Wayzata Boulevard
Minnetonka, MN 55305
Hennepin County

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

Evaluator's Name:
Maerin Renee, RN, 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) sexually abused the resident when the AP hugged and touched the resident inappropriately.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was inconclusive. The AP was observed on video engaged in an extended hug with the resident. However, the video footage was obscured, and there was a 4-minute block of time that was not recorded. The AP denied inappropriate physical contact beyond hugging, and no DNA evidence was collected when the resident visited the hospital. The resident was unable to be interviewed due to advanced dementia. It could not be determined if sexual contact occurred between the resident and the AP.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted family and law enforcement. The

investigation included review of the resident record, hospital records, the facility internal investigation, facility incident reports, personnel files, the law enforcement report, video footage, and related facility policy and procedures. Also, the investigator observed resident interactions with staff.

The resident resided in an assisted living memory care unit. The resident's diagnoses included Alzheimer's disease. The resident's services included assistance with activities of daily living (including grooming and dressing), meals, housekeeping/laundry, and medication management. The resident's assessment indicated the resident was at risk to be abused (physically, verbally, emotionally, financially, and/or sexually) due to a diagnosis of Alzheimer's disease.

Review of the facility internal investigation indicated the resident's family reported concerns regarding an inappropriate encounter between the resident and the AP, which they observed via video surveillance. The family alleged the AP's behavior constituted sexual "harassment" and reported the incident to law enforcement. Facility leadership interviewed the AP, and reviewed video footage provided by the family, as well as facility video footage. The internal investigation determined the AP engaged in a prolonged hug with the resident which was not appropriate and crossed professional physical boundaries. In addition, following the interaction, the AP was observed picking up the resident's camera, an action which led to suspicions regarding the AP's conduct. The AP was suspended pending the ongoing investigation.

The internal investigation indicated when the AP was interviewed, he stated he was passing medications when the resident said she wanted to go to bed. The AP said he opened her door and told her she needed to brush her teeth before she went to bed. The AP directed the resident to the bathroom. The AP said the resident put her hand out for a hug and he hugged her. The AP said he did not know how long the hug lasted. After they left the bathroom, the AP stated he saw something blinking, and he picked it up to see what it was and then put it back down (the item was one of the cameras in the resident's room). The AP stated when staff are assigned to pass medications, they also help with resident cares.

Review of the police report indicated the family placed cameras in the resident's room because they worried about her staying awake all night. The cameras that recorded this incident were positioned to capture the bathroom/bathroom hall and the resident's bed. When family reviewed the camera footage, it revealed the AP entering the resident's room. The AP brought the resident to the bathroom to brush her teeth. The police report indicated the AP appeared to hug the resident. Family stated they heard the AP tell the resident he loved her. The AP directed the resident, who shifted her body position toward the AP, with her back against the bathroom sink. The AP appeared to press himself against the resident, and the resident's hand could be seen moving up and down the AP's back. The AP was seen picking up and disabling the camera feed after he and the resident exited the bathroom. The family attempted to speak with the resident about the incident, but she did not remember the incident due to her memory loss. The police report indicated law enforcement reviewed the videos provided by family, and it was evident that physical contact occurred between the AP and the resident. The extent of physical

contact was unknown, as the wall/angle obstructed the area near the bathroom sink. There was a 4-minute period between clips that was not recorded, as the cameras were motion-triggered. The resident's hair and clothing appeared to be in similar orderly state when she both entered and exited the bathroom. Although law enforcement and family agreed it appeared no sexual intercourse occurred, both parties decided an examination completed by a Sexual Assault Nurse Examiner (SANE) would be in order. At a later point, it was discovered the SANE had not completed an evidence collection kit, so no DNA was collected. It was unclear why no kit was completed.

When interviewed by law enforcement, the AP said he helped the resident brush her teeth. The AP said he did not turn the camera off but simply moved it and was unaware the camera was off. The AP said he knew the resident liked to hug, and he hugged her but nothing else happened. The AP said he helped the resident get tucked into bed and left to complete his medication pass.

Law enforcement had no further information and the case was closed with no charges filed against the AP.

Review of five short video clips revealed the following:

Video 1 (Walking Toward the Bathroom):
The resident was seen at the foot of her bed walking toward the bathroom with the AP. The AP said something about getting ready for bed and brushing the resident's teeth, but the audio was distorted.

Video 2 (Inside the Bathroom):
The AP appeared to summon the resident into the bathroom. The AP said, "[resident's name], I love you." The resident responded, but the audio was distorted. The AP placed his left arm on the resident's upper back as they both stood near the sink. The resident's body position shifted toward the AP and they appeared to hug, but the angle and view were partially blocked by the bathroom wall.

Video 3 (Inside the Bathroom):
The AP appeared to shift the resident, so her backside was against the bathroom sink and she was facing the AP. The AP appeared to lean toward the resident, but she was not in view of the camera. The resident's hand could be seen moving up and down the AP's back.

Video 4 (Exiting the Bathroom):
The AP and resident exited the bathroom. The resident's clothing was not disheveled. The AP placed one glove on his right hand as he approached the camera. The AP picked up the camera with the gloved hand. The camera cut off.

Video 5 (View of the Bed):

The AP appeared to be talking to the resident while she was lying in bed. There was no physical contact.

When interviewed, the AP said he entered the resident's room because she said she was tired. The AP was passing medications, but he decided to help the resident get ready for bed since the aides were busy helping other residents. The AP denied physical contact with the resident beyond one hug. The AP said the resident did not ask for a hug, but she put out her hand as if asking for a hug. The AP said after he and the resident exited the bathroom, he saw something flashing on the floor. The AP walked to the item to see what it was. When he saw it was a camera, the AP said he set it down where he had found it.

When interviewed, a family member said they had placed cameras in the resident's room because they were concerned the resident was not sleeping at night. The family member stated they were concerned when they saw the interaction between the resident and the AP so they reported it right away.

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: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility completed an internal investigation. The AP was suspended pending results of the investigation.

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
	34716	A. BUILDING: _____ B. WING _____	C 03/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ORCHARDS OF MINNETONKA	10955 WAYZATA BOULEVARD MINNETONKA, MN 55305

(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 March 11, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL347166641C/#HL347168842M. No correction orders are issued.	0 000	The Minnesota Department of Health documents the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule number out of compliance are listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings, which are in violation of the state statute after the statement, "This Rule 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/RULES.	