Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL338046342M
Compliance #: HL338049483C

Date Concluded: February 5, 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:
Maerin Renee, RN, Special Investigator

Finding: Substantiated, individual 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 alleged perpetrator (AP) financially exploited the resident when the AP stole the residents wedding ring and pawned it for his personal gain.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was substantiated. The AP was responsible for the maltreatment. The resident and her family were unable to find the resident's wedding ring in her apartment after extensive searching. The family filed a police report and located the wedding ring at a local pawn shop. The police investigated and identified the AP pawned the resident's wedding ring. During an interview, the AP admitted to taking and pawning the residents wedding ring.

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 records, the facility internal investigation, facility

incident reports, personnel files, staff schedules, law enforcement report and related facility policy and procedures. Also, the investigator observed resident cares and resident interactions with staff.

The resident resided in an assisted living apartment. The resident's diagnoses included Parkinson's disease. The resident's services included assistance with activities of daily living, transfers, mobility, medication management, laundry, housekeeping, and meals. The resident's assessment indicated the resident was non-ambulatory and required continuous nursing care and observation.

Review of the facility internal investigation indicated the resident, and her family were unable to locate the residents wedding ring in the resident's apartment. The wedding ring was normally kept on the resident's nightstand in a ring holder. The resident's anniversary ring was still in the ring holder, but not the wedding ring. Continued searches by the family and facility staff failed to produce the wedding ring. Several weeks later, the local police department called reported they discovered the AP pawned the resident's wedding ring, as well as several other items. The police officer stated the wedding ring was originally purchased for $3000.00 but was unsure of its current value. Facility leadership removed the AP from the scheduled pending the facility investigation. Facility leadership met with the AP via telephone to discuss the findings, at which time the AP admitted to taking and pawning the residents wedding ring, as well as other unspecified items from the facility. The AP had a master key that gave him access to all apartments in assisted living and memory care.

Review of the police report indicated the police were investigating the AP for 609.52.2(a)(1) Theft-Take/Use/Transfer Movable Prop-No Consent: 23D Theft from Building, a felony. The police report was initiated by a family member who located the resident's wedding ring at a local pawn shop. The police followed up with a pawn shop manager who provided them with the date and time the wedding ring was pawned. The manager also provided the identity of the individual who pawned the wedding ring, who turned out to be the AP. The police discovered the AP had visited that pawn shop 11 times since the beginning of the year and pawned a total of 17 items, all similar high-value pieces of jewelry. The police verified the wedding ring at the pawn shop was the resident's missing wedding ring, and verified the AP was an employee of the facility. The AP secured a lawyer, and police were unable to coordinate an interview with the AP.

When interviewed, multiple staff supervisors said the resident's family notified leadership that the resident's wedding ring was missing. Staff and family searched extensively for the wedding ring but never found it. At that time, there was no suspicion that the wedding ring had been stolen. However, several weeks later, the police department notified the facility that the AP was suspected of stealing and pawning the resident's wedding ring. Facility leadership removed the AP from the schedule and questioned him regarding the missing wedding ring. The AP admitted to taking and pawning the wedding ring and possibly other items, but the AP did not elaborate. The AP's employment was termed.

When interviewed, a family member stated the resident did not normally wear her wedding ring but kept it in a ring dish on her dresser. While the resident's anniversary band was in the ring dish, the wedding ring was not. Over the next several weeks, the family and staff looked for the wedding ring. One night, the family member decided to visit a local pawn shop, just to look. The family member found the residents wedding at the pawn shop and notified law enforcement. The police verified the wedding ring belonged to the resident, and they identified the AP as the individual who pawned the wedding ring. The police verified with the facility that the AP was an employee and the facility completed their own investigation.

In conclusion, the Minnesota Department of Health determined financial exploitation 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.

Financial exploitation: Minnesota Statutes, section 626.5572, subdivision 9
"Financial exploitation" means:
(b) In the absence of legal authority a person:
(1) willfully uses, withholds, or disposes of funds or property of a vulnerable adult;
(2) obtains for the actor or another the performance of services by a third person for the wrongful profit or advantage of the actor or another to the detriment of the vulnerable adult;
(3) acquires possession or control of, or an interest in, funds or property of a vulnerable adult through the use of undue influence, harassment, duress, deception, or fraud; or
(4) forces, compels, coerces, or entices a vulnerable adult against the vulnerable adult's will to perform services for the profit or advantage of another.

Vulnerable Adult interviewed: No, no longer a resident of the facility.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: No, declined interview.

Action taken by facility:
The facility provided refresher training regarding vulnerable adult statutes to staff. The AP is no longer employed by the facility.

Action taken by the Minnesota Department of Health:
The facility was issued a correction order regarding the vulnerable adult's right to be free from maltreatment.

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

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

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Dakota County Attorney
Apple Valley City Attorney
Apple Valley Police Department
Minnesota Nurse Aide Registry

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 01/07/2025

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: #HL338049483C/#HL338046342M and #HL338043307C/#HL338047762M On January 7, 2025, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction order is 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/orders are issued for #HL338049483C/#HL338046342M, and #HL338043307C/#HL338047762M 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 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		

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 01/07/2025

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
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 two of two residents reviewed (R1 & R2) were free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility and an individual person were responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		