Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL338047443M
Compliance #: HL338047343C

Date Concluded: December 15, 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: Rhylee Gilb, 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):
It is alleged the alleged perpetrators (AP)1 and AP2 financially exploited the resident when the AP1 received a total of $1250 for services and helping AP1 financially. AP2 cashed a $1600 check from the resident without authorization.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was substantiated. AP1 was responsible for the maltreatment. AP2 was not responsible for maltreatment. AP1 violated the facility policy and provided services outside of her work hours to the resident for cash. The resident stated $150 was paid to AP1 for services such as moving boxes/furniture and cleaning up items. The resident stated two checks, one for $500 and one for $600 was given as an "advance" because AP1 had financial troubles. Additionally, AP1 stole a blank check, filled out the amount for $1600 made payable to AP2 so AP2 could cash the check for her because she did not have her identification. AP2 gave AP1 the full $1600 and did not receive any money.

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, bank records, facility internal investigation, personnel files, staff schedules, law enforcement report, related facility policy and procedures.

The resident resided in an assisted living facility. The resident's diagnoses included Parkinson's disease. The resident's service plan included assistance with weekly showers and homemaking. The resident's assessment indicated she was cognitively intact and easily understood. The assessment indicated she had dystonia (muscle contraction) in her right hand.

The resident's service delivery records indicated AP1 provided services to the resident. AP2 did not provide services.

Review of bank records indicated five checks were written and cashed within a week. Four of the checks were written in sequential check number order in the amounts of $50, $100, $600 and $1600. A fifth check in the amount of $500 was two check numbers after the $1600 check. The checks were all written to AP1 and were either cashed or deposited by AP1, aside from the $1600 check made out to AP2. AP2 cashed the $1600 check.

The staff schedule on the date the $1600 check was cashed indicated both AP1 and AP2 worked that day, ending their shifts at 3:15 p.m.

Four days later, the resident's progress notes indicated she had professional organizers hired to her clean and organize her apartment. Later that same month, the resident reported to the facility leadership of a theft of her check.

The facility internal investigation indicated the resident had a check cashed for $1600 and did not recognize the name or authorize a check for that amount. The facility suspended AP1 and AP2 and conducted an investigation. The facility also reported to law enforcement. AP2 stated she knew AP1 completed side jobs for the resident and the payment was for side work. AP2 stated AP1 did not have her identification to cash the check, so after their shift they went to the bank and she cashed it for AP1. AP1 failed to answer calls from the facility.

Law enforcement provided an audio recording of AP1's interview. AP1 stated she did side work for clients and the resident became one of her clients. AP1 stated she had been helping her for a couple of months with moving furniture, clean her residential house out and helped with a bath. AP1 stated she was paid by accumulation of work when the resident was ready to pay her. AP1 state she received $150. AP1 told law enforcement she thought the last check she received was roughly $1500. AP1 stated her phone battery was low and the call ended. AP1 failed to respond to further attempts of contact.

During an interview, the resident stated due to Parkinson's she had mobility issues, and her hands were shaky causing an inability to write well. The resident stated her spouse had health

issues and before he went to the hospital/transitional care unit he signed a few blank checks, so the resident was able to pay for things while he was gone. The resident stated AP1 was an unlicensed staff who worked with her frequently at the facility; she was competent and helpful. The resident stated her and AP1 had a connection because AP1's children were similar ages as her grandchildren. The resident stated she began having AP1 help her outside of her facility working hours to assist with opening boxes, helping with furniture and other things. The resident stated she paid AP1 what she thought was reasonable for her time to help, which were the $50 and $100 checks. The resident stated that was how the relationship developed, but then AP1 began to have financial troubles within a couple of weeks, such as car issues and health issues. AP1 had a $300 past due phone bill resulting in her cellphone being turned off. The resident stated she felt bad and did not want AP1's children not able to contact her. The resident stated she made an agreement with AP1 that she would give her an advance and AP1 could work off payment or AP1 could pay her back. The resident stated AP1 filled in the check amount while with the resident present and at her directive due to her inability to write well. The resident stated the checks for the amounts of $500 and $600 were the advance to AP1 with the expectation she would pay her back (via services or payment). The resident stated when she was checking her bank account, she saw a check was cashed for $1600. The copy of the check on the bank record had a name she was unfamiliar with. The resident stated did not want to believe it at first that AP1 would do this, but then reported to the facility leadership the stolen check and to inquire if they knew the name on the check. The resident learned the check was written to AP2, another unlicensed staff member of the facility. The resident stated she had heard of AP2 and believed she worked in the memory care unit. The resident stated AP2 had never provided cares for her at the facility, nor had she had interactions with her. The resident stated she did not notice AP1 do it at the time, but believed AP1 took the blank check when she filled out the check for $600 because the check number of the check for $1600 was the next check number. Additionally, there was no duplicate for the $1600 check like the other checks. The resident stated she never authorized a $1600 check to AP1 or AP2.

During an interview, AP2 stated she was friends with AP1 and would periodically give her rides. AP2 stated she knew AP1 had been doing work for the resident outside of work hours. AP2 stated she typically works an evening shift, however the day of the incident she worked a morning shift ending at 3:00 p.m. Shortly before the shift ended, AP1 approached her to ask if she could cash a check for her after work because she forgot her identification. She stated AP1 called the resident to ask her if it was ok to put AP2's name on the check because AP1 did not have her identification. AP2 stated she assumed AP1 was talking to the resident, although she did not hear the conversation. AP2 stated AP1 left to get the check from the resident and AP1 met her in the car. AP2 stated when she saw the check it was already filled out and had her name on it. AP2 stated she went to the bank with AP1, cashed the check and gave AP1 the full amount of $1600. AP2 stated she did not know the resident did not authorize a check to AP1 in that amount. In hindsight, AP2 stated she should have reported it to a supervisor because staff are not allowed to accept gifts from residents.

AP1 failed to participate in an interview. During the scheduled interview, AP1 asked to have the interview changed to a later date. When called for the rescheduled interview, AP1 answered the phone but then failed to respond to the investigator. The line remained connected, however AP1 failed to say anything.

Facility policy indicated gifts from residents are not expected as part of compensation to staff due to the inequity between the employee and the resident. Facility staff were prohibited from accepting a gift.

Review of AP1 and AP2's personnel file records indicated the annual training included training on the Vulnerable Adult Act, fraud/waste and abuse and code of conduct (which included the facility gift policy). AP2 completed annually training approximately six months prior to the incident. AP1 completed training one month prior to the incident.

During an interview, the licensed assisted living director (LALD) stated the resident reported to her the situation with AP1 and that she had been paying AP1 for home-making services outside of work. The resident paid AP1 $500 and $600 as a pre-payment to help AP1. The resident stated she did not give anyone permission for a $1600 check. The LALD stated employees cannot take any payment from residents. An employee could volunteer to help, but should not be doing any services outside of work for the resident. The LALD stated the resident was concerned how she would get that money back. The LALD stated when conducting the internal investigation, AP1 stated she would not talk until after she spoke to law enforcement. When she received an update law enforcement talked to AP1, the LALD called AP1 again. When asked directly about the $1600 check, AP1 refused to answer and disconnected the call. AP1 texted her phone died. AP1 did not participate in any further questioning by the facility leadership. The LALD stated both AP1 and AP2 no longer work for the facility. The LALD stated all staff were retrained on the gift policy and reporting after the incident.

During an interview, the nurse stated he assessed the resident after the incident and updated her abuse prevention plan to reflect the financial abuse. The nurse stated the resident's family member will also assist the resident in monitoring her accounts and every 90 days the facility would check in with the resident.

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.

Mitigating Factors considered, Minnesota Statutes, section 626.557, Subd. 9c(f):

(1) AP1 did not follow an erroneous order, direction or care plan with awareness and failure to take action.

The facility did not direct an erroneous order, direction, or care plan.

(2) The facility was in compliance with regulatory standards.

The facility provided proper training and/or supervision of staff.

The facility provided adequate staffing levels.

AP1 failed to follow the facility directive and/or policies and procedures.

(3) AP1 failed to follow professional standards and/or exercise professional judgement.

AP1 failed to act in good faith interest of the vulnerable adult.

The maltreatment was not a sudden or foreseen event.

Vulnerable Adult interviewed: Yes.
Family/Responsible Party interviewed: Attempted.
Alleged Perpetrator interviewed: Yes, AP2. AP1 declined.

Action taken by facility:
The facility completed an internal investigation, reported to law enforcement and completed retraining with staff. The facility assessed the resident and implemented measures to help safeguard her finances. AP1 and AP2 no longer work for 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

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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	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

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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		