

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL338048543M
Compliance #: HL338041461C

Date Concluded: April 27, 2026

Name, Address, and County of Licensee

Investigated:

Orchard Path
5400 157th Street W.
Apple Valley, MN 55124
Dakota County

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

Evaluator's Name: Michele Larson, 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):

A facility staff member/alleged perpetrator (AP) neglected a resident when they failed to provide care, services, and supervision as indicated in the resident's care plan. The resident fell, sustained a brain bleed and died.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined neglect was substantiated. The AP was responsible for the maltreatment. The AP failed to follow the resident's plan of care, did not complete scheduled rounds and left the resident unsupervised in the bathroom. The resident fell, sustained head injury requiring hospitalization in the intensive care unit (ICU) and died several weeks later.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The AP was interviewed. The investigator contacted the resident's family members. The investigation included review of the resident's facility record,

death record, hospital record, facility internal investigation, facility incident reports, personnel files, staff schedules, law enforcement report, photos of the resident's injuries, and related facility policy and procedures. Also, the investigator observed staff and resident interactions during her onsite visit.

The resident resided in an assisted living memory care unit. The resident's diagnosis included dementia. The resident's care plan indicated the resident received assistance with personal cares, medication management, and safety checks. In addition, the resident required staff supervision while using the bathroom due to her high risk for falls. The resident's assessment indicated the resident had severe cognitive impairment and was unable to use her call pendant. The resident used a walker and a wheelchair for mobility.

The resident's medical record indicated day shift staff found the resident on the bathroom floor during their morning rounds around 7:15 a.m. Due to the resident's injuries, the resident was transported to the emergency department and admitted to the hospital.

A police report from the time of the incident indicated the resident had a significant amount of dried blood on her head and face as well as her hands, eyes, and neck. In addition, there was a large hematoma and swelling near the resident's right eye and cheek and a cut that was actively bleeding. The resident appeared confused and disoriented and was unable to state what happened or how long she had been on the floor. An unlicensed staff member told police the staff member/alleged perpetrator (AP) assigned to care for the resident during the overnight shift left quickly after her shift ended and mentioned no concerns. Police told leadership due to the amount of dried blood the resident had on her body the resident most likely had been on the floor for hours.

The facility's internal investigation report indicated another unlicensed staff stated during the end of shift rounds around 5:30 a.m., the AP told her the resident was in the bathroom. She reminded the AP about checking on residents in the bathroom but did not see the AP go back in the resident's room. Camera footage reviewed showed the AP did not complete scheduled rounds during the night but did show the AP going in and quickly coming out of the resident's apartment around 5:40 a.m. When interviewed by facility management, the AP's statements changed several times stating initially the resident was in her bed during her 5:30 a.m. check and when questioned again, indicated the resident was in the bathroom. The AP acknowledged she did not complete all scheduled rounds during the shift.

The resident's hospital record indicated the resident was diagnosed with acute epidural hematomas (a serious rapid collection of blood outside the brain tissue but inside the skull from head trauma) on the right side of the resident's temple and forehead, and a subdural hematoma (slower bleeding between the skull and brain tissue). The resident was admitted to the ICU for four days then discharged back to the facility. However, two days later the resident was sent back to the hospital due to increased weakness and low blood pressure. The resident remained in the hospital and died three weeks later.

The resident's death record identified the cause of death as complications of intracranial hemorrhage, blunt head trauma and fall.

Review of the AP's personnel file indicated the AP had received training and passed competency skills evaluations.

The AP did not respond to requests for interview.

When interviewed, a staff member stated the AP told her all the residents were "fine" when she arrived to work the morning shift. The staff member stated she entered the resident's apartment to perform a morning check and found the resident sitting on the floor next to the stating, "it was a terrible sight," and there was blood everywhere. The staff member said the resident's eyes were bloody and swollen and the resident had blood on her face and hands.

When interviewed, the nurse indicated the resident was at high risk for falls and the resident's care plan was recently updated due to increased care needs. The nurse stated she was told by staff the resident was found in her apartment and was "bleeding all over the place." The nurse stated due to the amount of dried blood the resident had on her face and body, emergency medical technician (EMT)s believed the resident was not checked on for several hours.

When interviewed leadership stated they reviewed camera footage immediately after the incident and noticed the AP did not complete scheduled rounds on the resident. The camera footage did show the AP enter the resident's apartment at the end of her shift and were surprised at how quick the AP entered and left the resident's apartment, stating the AP spent maybe "five seconds" inside the resident's apartment. Leadership questioned the amount of time the resident was on the floor due to the AP not completing rounds during the night and emergency responder's concern of the amount of dried blood on the resident. Following completion of the internal investigation, the AP's employment was terminated.

In conclusion, the Minnesota Department of Health determined neglect was substantiated.

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. The resident is deceased.

Family/Responsible Party interviewed: Yes.

Alleged Perpetrator interviewed: No. AP did not respond to request for interview and did not respond to subpoena requests.

Action taken by facility:

The AP is no longer employed at the facility. The facility completed staff training following the incident.

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 Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33804	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/11/2026
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NAME OF PROVIDER OR SUPPLIER ORCHARD PATH	STREET ADDRESS, CITY, STATE, ZIP CODE 5400 157TH STREET WEST APPLE VALLEY, MN 55124
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(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
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0 000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>ASSISTED LIVING PROVIDER CORRECTION ORDER</p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation.</p> <p>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.</p> <p>INITIAL COMMENTS:</p> <p>#HL338041461C/#HL338048543M</p> <p>On February 11, 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 93 residents receiving services under the provider's Assisted Living with Dementia Care license.</p> <p>The following correction orders are issued for #HL338041461C/#HL338048543M, tag identification 2360.</p>	0 000	<p>Assisted Living Provider 144G.</p> <p>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.</p> <p>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.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p> <p>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.</p>	
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Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Minnesota Department of Health

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02360	Continued From page 1	02360		
02360	<p>144G.91 Subd. 8 Freedom from maltreatment</p> <p>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.</p> <p>This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident(s) reviewed (R1) was free from maltreatment.</p> <p>Findings include:</p> <p>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.</p>	02360		