Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL347168405M
Compliance #: HL347165642C

Date Concluded: December 20, 2023

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: Danyell Eccleston, 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), facility staff, abused a resident when the AP hit and was physically rough with a resident.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was substantiated. The AP was responsible for the maltreatment. The AP was physically rough and hit a resident multiple times with a closed and open hand. The resident had injuries to her arms and ankle.

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 medical records, employee records, policies and procedures, surveillance videos, photographs, and law enforcement reports. Also, the investigator observed facility staff members interacting and caring for memory care residents.

The resident resided in an assisted living memory care unit. The resident's diagnoses included Alzheimer's disease. The resident's service plan included assistance with dressing, grooming, toileting, and behavior management. The resident's service plan indicated staff should allow time and reapproach when the resident refused cares and to have a different caregiver attempt cares if the resident refused a third time. The resident's assessment indicated she verbally communicated in words or phrases that were out of order or context, had delayed response, and needed additional time for communication.

Review of a facility incident report indicated a caregiver witnessed the AP hit the resident while providing cares. The report indicated the AP hit the resident several times on the left upper arm, shoulder, left forearm, and left inner leg. A nurse came to the facility and assessed the resident the same evening. The nurse noted the resident had a skin tear measuring 3.75 centimeters by 0.5 centimeters to the left forearm that was bleeding, a quarter sized bruise to the right forearm, and a quarter size bruise to the inner lower right leg next to the ankle.

The facility's internal investigation indicated leadership interviewed the AP the day after the incident. The AP stated she put her hand around the resident's hand to walk the resident to her room and the resident was not resistive. The AP indicated the resident "wanted to be tough" and "was being sassy" during evening cares and the resident was combative when having her clothes changed before bed. The AP denied hitting the resident.

The facility's internal investigation indicated another caregiver stated she witnessed the AP abuse the resident. The caregiver stated the resident did not want to walk to her room, but the AP locked arms with the resident and pulled the resident to her room. The staff stated the AP roughly removed the resident's clothing while the resident was sitting on the toilet and the resident became stiff and did not want to cooperate. The staff stated the AP told the resident "If you hit me, I will punch you back." The resident lifted her arms, and the AP struck the resident in the left upper arm three times. When the AP removed the resident's socks, the resident lifted her leg and then AP struck the back of the resident's legs. The AP told the resident to go to bed, walked out of the resident's room, and locked the resident's door leaving the resident standing alone in her room.

Review of recorded video of the memory care unit from the time of the incident showed the AP lacing arms with the resident and forcing the resident to walk down the hallway. The video showed the resident attempting to not walk with the AP and thrust away from the AP. The AP continued to lace her arm with the resident's arm despite the resident's efforts to not walk with the AP.

Review of photographs taken after the incident showed the resident with injuries to her arms and right ankle.

During interview, a caregiver stated she worked with the AP on the memory care unit the evening of the incident. The staff stated the AP wanted to finish evening and bedtime cares

quickly so she could have little work left the remainder of the shift. The caregiver stated she and the AP approached the resident in the television room and the AP grabbed the resident by the arm and pulled the resident to her room despite the resident's resistance to going with the AP. The staff stated the resident was brought to use the bathroom and the AP stated to the resident, "If you hit me, I'll hit you back." The resident sat on the toilet and the AP quickly tried to remove the resident's clothing. The resident raised her hand, and the AP used a closed fist to hit the resident in the arm. The resident attempted to block the AP and the AP hit the resident four times in the upper arm. The caregiver stated the resident said "ow" when the AP was hitting her. The resident lifted her legs to prevent the AP from removing her pants. The AP hit the resident in the leg with an open hand three times. The caregiver stated she was very uncomfortable with the situation and tried to step in to assist. The caregiver stated she helped finish dressing the resident and the resident was left standing in her room. The caregiver stated after exiting, the AP locked the resident's door.

During interview, a nurse stated staff contacted her regarding reports of the AP hitting the resident. The nurse called the AP who told the nurse "nothing happened" and the shift was "going fine." The nurse instructed the AP to leave the facility until the allegation was internally reviewed. The nurse went to the facility to check on the resident and the resident's room was locked when she arrived. The nurse stated she assessed the resident and noted an actively bleeding skin tear to the resident's arm and bruising to the resident's arms and ankle that appeared fresh. The nurse also reviewed surveillance video of the time in question and stated the video showed the AP lock arms with the resident and pull the resident. The nurse stated the AP took the resident's arm forcefully and the resident did not want to go with the AP, and the AP should have reapproached the resident later.

During interview, a leadership member stated she never witnessed the AP providing in-room cares to residents, but did witness the AP being verbally "gruff" with residents in the facility common areas. Leadership stated the resident was very agile and liked to walk around the unit. The resident responded well to nonverbal engagement and, despite speaking in a confused mix of words, the resident verbalized "no" and communicated non-verbally with actions when she did not like or want to do something. Leadership stated the resident could be resistive to cares and become physically aggressive and staff were directed to give the resident some time and then reapproach the resident later. Leadership also stated the day after the incident, the resident was not her usual self; the resident was not smiling, kept her distance, and seemed disinterested and unwell.

During interview, the AP stated it was not okay to yell at, hit, or pull a resident. The AP stated residents have the right to refuse cares and staff members should reapproach residents later when cares are refused. The AP stated the night of the incident the resident agreed to go to her room and receive cares during the time of the alleged incident. The AP stated she "danced" with the resident in the common area to get the resident to her room. The AP stated the resident could be combative and when the AP helped remove the resident's pants, the resident hit her in the back. The AP stated she asked another caregiver to help hold the resident's hands

so she could finish getting the resident changed. The AP stated she then left the room because the resident could finish getting herself to bed. The AP stated later that evening, a nurse called her to ask if something had happened with the resident. The AP told the nurse there were no problems and the nurse told the AP to clock out and go home. The AP stated she then went in to check on the resident and noted a scrape on the resident's hand that she believed could have occurred when the other caregiver held the resident's hands due to the caregiver having long nails. The AP denied hitting the resident and stated she did not reapproach the resident when the resident was resistive to cares because the resident's pants were urine soaked and the resident needed to be changed.

In conclusion, the Minnesota Department of Health determined abuse 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.

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;

Vulnerable Adult interviewed: No, due to cognitive state.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility investigated the incident.
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.

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
Hennepin County Attorney
Minnetonka City Attorney
Minnetonka Police Department

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 11/21/2023

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 ******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: #HL347165642C/ #HL347168405M On November 21, 2023, 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 66 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for ##HL347165642C/#HL347168405M, tag identification 2360.	0 000		
02360	144G.91 Subd. 8 Freedom from maltreatment 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.	02360		

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02360	Continued From page 1 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. 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	No plan of correction is required for this tag.	