Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL390343662M
Compliance #: HL390347047C

Date Concluded: October 15, 2025

Name, Address, and County of Licensee Investigated:
Norbella Senior Living
8700 Emery Parkway North
Champlin, MN 55316
Hennepin County

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

Evaluator's Name: Holly German, 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) abused the resident when the AP performed unwanted touch of the resident's breast.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was substantiated. The AP was responsible for the maltreatment. The facility surveillance footage showed the AP approach the resident, who was sitting calmly near the nurse's station, and place her arm around the resident's shoulders, place her hand on the resident's breast, and move her hand around on the resident's breast in a groping motion. This action resulted in the resident becoming upset and physically grabbing the AP's hand and pushing it away from her. The AP continued to attempt to physically touch the resident's hands and/or arms, and the resident continued to push the AP away from her.

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The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement and a family member. The investigation included review of the resident records, facility internal investigation, facility incident reports, personnel files, staff schedules, law enforcement report, and related facility policy and procedures. Also, the investigator observed staff interactions with the resident while on site.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia and adjustment disorder. The resident's service plan included assistance with behavior observation, safety checks, toileting, and dressing. The resident's assessment indicated the resident required assistance with mobility in her wheelchair, and may require staff intervention for refusals of care, verbal and physical aggression, and wandering into others' space.

A facility incident report indicated the resident was sitting in her wheelchair next to the nurse's station when the AP approached the resident and draped her arm around the resident's shoulders. The report indicated the AP placed her left hand on the resident's left breast, and the resident attempted to remove the AP's arm from her shoulder and roll herself away from the nurse's station. The report indicated the AP grabbed the front of the resident's wheelchair and pulled her back towards the nursing station. The resident swatted the AP's hand away, grabbed the AP's hand and twisted the AP's arm. The report indicated the resident then let go of the AP's arm and backed herself away from the AP. The AP attempted to grab the resident's wheelchair, and the resident then attempted to hit and kick the AP. The report indicated unlicensed personnel (ULP)-4 walked over to the resident, and the AP then left the interaction.

The investigator viewed the facility video surveillance footage of the reported incident. The investigator watched the footage and observed the resident sitting in her wheelchair by herself at the nurse's station. The resident appeared calm and quiet. The AP approached the resident from behind and placed her arm around the shoulders of the resident. The AP then made a groping motion, cupping from the top of the resident's left breast with her left hand. The AP did not touch the side of the bra, in an action of pulling the bra down for adjusting. The resident became agitated and attempted to remove the AP's arm from her. She move her wheelchair back and away from the AP. The AP then grabbed the front arm rest bar of the wheelchair and pulled the resident back toward her. The resident became further agitated and attempted to hit the AP. The AP continued to attempt to grab the resident's wheelchair and pull the resident close to her.

The law enforcement report indicated law enforcement responded to the facility for unwelcome sexual contact to a resident by an employee. The report indicated the officer viewed the video surveillance footage and observed the AP place her open left hand on the resident's left breast over her clothing, and the resident appeared startled by the touch.

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During investigative interviews, other ULP stated staff are trained on abuse and it would not be ok for a staff member to touch or grope a resident's breast on top of their clothes. Staff should not touch a resident's breast aside from helping them get dressed. ULPs stated if a resident was agitated, staff should not continue to aggravate them.

During an interview, ULP-4 stated she was being trained by the AP as it was her first day in the building when the AP touched the resident. ULP-4 stated she thought the AP was tickling the resident in her armpit, and the resident became agitated. ULP-4 stated the AP told her it was the time of day the resident always gets agitated.

During an interview, ULP-1 stated staff received training on abuse and neglect, and it would not be appropriate for staff to touch a resident's breast. ULP-1 stated she did not have any concerns about how the AP treated residents. ULP-1 stated the AP told her she attempted to adjust the resident's bra for her, and that was why she touched the resident's breast.

During an interview, the executive director (ED) stated staff are trained on abuse and how to deescalate agitated residents. The ED stated she interviewed the AP about the incident she observed on the facility video surveillance with her and the resident, and the AP told the ED she jokes around with the resident. The ED stated the AP never told her she was adjusting the resident's bra.

During an interview, the nurse stated the abuse training staff received included training on inappropriate touch of residents. The nurse stated she watched video footage of the AP and the resident. The nurse stated the resident was observed to be sitting quiet, not bothering anyone, when the AP put her hand on the resident's breast and squeezed the resident's breast. The nurse stated the resident then tried to push away from the AP, and the more the resident pushed away, the more the AP pulled her back to her. The nurse stated she spoke to the AP about the incident, and the AP told her she was just playing around with the resident. The nurse stated the AP never mentioned to her about adjusting the resident's bra.

During an interview, the AP stated she was trained on abuse and what was and was not appropriate touching of a resident. The AP stated the resident was wearing a bra, and the resident kept pushing the bra up. The AP stated she told the resident to let her fix it, let her pull it back down. The AP stated the resident had an attitude, so she wanted to keep the resident near her and away from other residents since she was agitated. The AP stated she tried to get the bra down in place so her breast was not under it when she went to an activity. The AP stated she only touched the resident's breast to fix the bra, so the resident would not be embarrassed. The AP stated she would never harm the resident.

During an interview, a family member stated the resident had severe dementia and did not remember things for more than twenty minutes. The family member stated the facility notified him there had been an incident where a staff member attempted to move the resident back

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from the nurse's station and had touched the resident's breast when attempting to move her. The family member stated he did not have any concerns about the care the resident received.

The resident was unable to complete an interview due to lack of cognitive ability.

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;
(4) criminal sexual conduct in the first through fifth degrees as defined in sections 609.342 to 609.3451.
(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.

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

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

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

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

The maltreatment was not a foreseen event.

Vulnerable Adult interviewed: No, unable to complete.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility investigated in the incident and 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
Hennepin County Attorney
Champlin City Attorney
Champlin Police Department

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39034	A. BUILDING: _____ B. WING _____	C 08/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORBELLA OF CHAMPLIN LLC	8700 EMERY PARKWAY NORTH CHAMPLIN, MN 55316

(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: HL390347047C/HL390343662M HL390347048C/HL390343663M HL390347049C/HL390343664M On August 18, 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 37 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued/orders are issued for HL390347047C/HL390343662M, tag identification 2360. No correction orders are issued for HL390347048C/HL390343663M, HL390347049C/HL390343664M.	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.	

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02360	Continued From page 1	02360		
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. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one residents 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		

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