Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL213872043M
Compliance #: HL213873449C

Date Concluded: July 29, 2025

Name, Address, and County of Licensee Investigated:
Rose Arbor Wildflower Lodge
16500 92nd Avenue North
Maple Grove, MN 55311
Hennepin County

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

Evaluator's Name: Lena Gangestad, RN
Special Investigator

Finding: Inconclusive

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 she reached across the table to the resident, hit his hand, and said, "You better not spit out these meds."

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was inconclusive. The AP denied the allegations, and the resident could not be interviewed due to her cognitive impairment. While there was a witness and it was inconclusive the AP's action met the definition of abuse or treated the residents in a discourteous manner. There was no incident report or documented corrective actions against the AP.

The investigator conducted interviews with facility staff members, including administrative staff, and unlicensed staff. The investigation included review of the resident's records, personnel files, staff schedules, policies, and procedures.

The resident resided in an assisted living secured memory care building. The resident's diagnoses include dementia. The resident's service plan included assistance with all activities of daily living.

The resident's assessment, completed two months prior to the incident, indicated the resident required medication administration up to four times daily and did not require special medication preparation or additional time to take medications.

One day during rounds, the manager observed AP reach across the table "swatting" the resident's hand. The AP stated, "You better not spit out these meds." The resident responded that the medication tasted bad, and he did not like it. The AP crushed medications and mixed the medications in chocolate syrup without a physician's order.

The resident's progress note a few days later indicated hospice ordered to crush all of the resident's medications and mix them with chocolate syrup or chocolate pudding. The note also stated it was acceptable to hold medications if the resident refused to take them.

The resident's record lacked an incident report or progress note regarding the incident.

The AP's personnel file lacked documentation of the incident or corrective actions.

During an interview, the manager stated she witnessed the AP reach across the table, hit the resident's hand, and say, "Do not spit out the medication." The manager checked on the resident and then instructed the AP to leave him alone and not to hit him. The manager also stated that the AP had not administered the medication as instructed. Per the physician's order, the medication was to be crushed and mixed with chocolate pudding. Instead, the AP gave the medication whole, despite the resident's history of spitting it out. The manager noted that she had informed the AP of this order multiple times, but the AP claimed she was unaware of it. Due to inconsistencies among staff awareness, the manager requested the physician reissue the order.

During an interview, the community staff stated she did not witness the incident but confirmed the AP had failed to follow the physician's order to crush the medication and mix it with pudding or syrup. When questioned, the AP told her she did not believe it was necessary to crush the resident's medication.

During an interview, the AP stated the resident was often reluctant to take medication and would sometimes spit it out depending on his mood. She said that on the day in question, she simply touched his shoulder and called his name to ask him not to spit out the medication. She denied saying, "You better not spit out this medication."

During an interview, the family stated she had no concerns about the care the resident received.

In conclusion, the Minnesota Department of Health determined abuse was inconclusive.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or did not occur.

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; 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.
(d) The act of forcing, compelling, coercing, or enticing a vulnerable adult against the vulnerable adult's will to perform services for the advantage of another.

Vulnerable Adult interviewed: no, unable to participate in an interview due to dementia.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility reported the incident.

Action taken by the Minnesota Department of Health:
No further action taken at this time.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21387	A. BUILDING: _____ B. WING _____	C 05/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE ARBOR/WILDFLOWER LODGE	16500 92ND AVENUE NORTH MAPLE GROVE, MN 55311

(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 On May 14, 2025, the Minnesota Department of Health initiated an investigation of complaint HL213872043M/HL213873449C and HL213871903M/HL213873194C. Violations were found for HL213871903M/HL213873194C but not issued due to open survey #SL21387016-0 No correction orders are issued for HL213872043M/HL213873449C and HL213871903M/HL213873194C.	0 000		