DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL306412620M
Compliance #: HL306419600C

Date Concluded:

Name, Address, and County of Licensee Investigated:
Maple Care Homes
14424 Lower Guthrie Ct
Apple Valley, MN 55124
Dakota County

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

Evaluator's Name: Brandon Martfeld, RN, BSN, Special Investigator

Finding: Substantiated, facility 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 facility neglected the resident when the resident had a change in condition resulting in various bruises, lacerations, a malfunctioning catheter, a left hip fracture, and hospitalization.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. Facility staff did not notify nursing leadership that the resident fell twice, and after the falls the resident required assistance for transfers and walking. The resident was not assessed after the falls, and the resident's change in condition was not communicated to nursing leadership. The resident was transferred to the hospital two days after the falls.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident records,

hospital records, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed staff and resident interactions.

The resident resided in an assisted living memory care unit. The resident's diagnoses included epilepsy and retention of urine. The resident's service plan included assistance with medication administration, catheter care, and an epilepsy/seizure action plan. The resident's assessment indicated the resident was alert, orientated, and was independent with dressing, grooming, bathing, transfers and walking. The resident's assessment indicated the resident needed assistance with ordering catheter supplies and a clinic managed the resident's catheter changes.

The resident's medical records indicated over a weekend the resident had two falls in one day. The first fall occurred when the resident began having "convulsions" and fell off the couch onto the floor. Staff assisted the resident off the floor and back onto the couch. Approximately two hours later, the resident was found on the floor in the bathroom. Staff again assisted the resident off the floor and back onto the couch. The next day, the resident was tired, weak and needed assistance with walking. On the third day, a staff member entered the facility and found the resident sleepy, lethargic, and drowsy. The resident had a bruise on his right knee and a one inch cut over his left eye. The staff member called emergency medical services and the resident transported to the hospital.

Hospital records indicated emergency medical services were sent to the facility because the resident had a stroke. Emergency medical services found the resident lying in bed crying and facility staff reported the resident was lethargic and had altered mental status. The resident reported he had pain in his upper left leg that was new since the fall. The hospital record indicated the resident fell several days ago, had a blood infection, and metabolic encephalopathy (a brain dysfunction caused by systemic illnesses—such as organ failure (liver, kidney, heart), infection or severe electrolyte imbalances—rather than structural damage). The resident was "critically ill" and had acute and life-threatening abnormalities. The hospital record indicated the resident had fractures to his left femur and to his thoracic spine of the T5 and T7 vertebrae. The hospital record indicated the resident was unable to explain why emergency medical services were not called sooner. The resident's health condition carried a high risk for death.

A picture from the hospital record showed the resident's left hip and femur protruded to the left side from the hip area to above the left knee.

The resident's medical record lacked evidence that nursing leadership was updated about the resident's falls. Nursing leadership did not assess the resident after the resident had a change in condition.

During an interview, unlicensed staff member #2 stated when a resident falls, staff were to call emergency medical services and the facility nurse. Unlicensed staff member #2 stated the resident had two falls two days prior to being hospitalized. The first fall occurred when the

resident was found on the floor next to the couch. The resident was assisted off the floor and back onto the couch. Then a co-worker called and stated the resident was on the floor for a second time. The resident was assisted back onto the couch. Unlicensed staff member #2 stated she did not see the resident fall and was not aware if the facility nurse was notified of the resident's falls.

During an interview, unlicensed staff member #4 stated she came in for shift and was told the resident had fallen on the previous shift. Unlicensed staff member #4 stated it was reported to her that a message was written to the nurse in the computer system, regarding the resident's falls. Unlicensed staff member #4, stated the resident looked sick, needed to be seen by a doctor, and had written a message in the computer to the nurse regarding the resident's condition.

During an interview, unlicensed staff member #3 stated the resident's roommate notified him that the resident fell. The roommate stated the resident had fallen twice the day before. The resident normally walked independently but the day he was scheduled to work with the resident, the resident needed assistance with walking. The resident had a bruise on his head and was not looking well. Unlicensed staff member #3 stated he updated a licensed nurse but did not notify nursing leadership.

During an interview, nursing leadership stated the resident was sent to the hospital because of weakness. Nursing leadership reviewed the computer messages entered by staff twice a week. When the messages were reviewed, it was determined the resident fell two days prior to the hospital transfer. Nursing leadership stated staff did not immediately notify her that the resident fell twice.

During an interview, an emergency room nurse stated when the resident arrived at the hospital, he looked "horrible." The resident's blood pressure was low, he was confused, and his catheter was leaking. The resident had bruises on his face, right arm, right leg, feet, and a dark purple bruise on his left hip. An x-ray was completed to his left hip, and it was found to be "shattered." The emergency room nurse stated his potassium and calcium levels were low which can cause an irregular heartbeat. The resident had a high international normalized ratio (INR) which put him at risk for bleeding. The resident was medically unstable for surgery on the fractured hip.

During an interview, a family member stated during a phone call a week or two before the hospitalization the resident stated everything was fine at the facility. Then one day the hospital called, saying the resident was hospitalized, had a fractured femur, was in the intensive care unit and was connected to a ventilator because he was not breathing on his own.

In conclusion, the Minnesota Department of Health determined neglect 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.

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.
(d) For purposes of this section, a vulnerable adult is not neglected for the sole reason that:
(1) the vulnerable adult or a person with authority to make health care decisions for the vulnerable adult under sections 144.651, 144A.44, chapter 145B, 145C, or 252A, or sections 253B.03 or 524.5-101 to 524.5-502, refuses consent or withdraws consent, consistent with that authority and within the boundary of reasonable medical practice, to any therapeutic conduct, including any care, service, or procedure to diagnose, maintain, or treat the physical or mental condition of the vulnerable adult, or, where permitted under law, to provide nutrition and hydration parenterally or through intubation; this paragraph does not enlarge or diminish rights otherwise held under law by:
(i) a vulnerable adult or a person acting on behalf of a vulnerable adult, including an involved family member, to consent to or refuse consent for therapeutic conduct; or
(ii) a caregiver to offer or provide or refuse to offer or provide therapeutic conduct; or
(2) the vulnerable adult, a person with authority to make health care decisions for the vulnerable adult, or a caregiver in good faith selects and depends upon spiritual means or prayer for treatment or care of disease or remedial care of the vulnerable adult in lieu of medical care, provided that this is consistent with the prior practice or belief of the vulnerable adult or with the expressed intentions of the vulnerable adult;
(3) the vulnerable adult, who is not impaired in judgment or capacity by mental or emotional dysfunction or undue influence, engages in consensual sexual contact with:
(i) a person including a facility staff person when a consensual sexual personal relationship existed prior to the caregiving relationship; or
(ii) a personal care attendant, regardless of whether the consensual sexual personal relationship existed prior to the caregiving relationship; or
(4) an individual makes an error in the provision of therapeutic conduct to a vulnerable adult which does not result in injury or harm which reasonably requires medical or mental health care; or
(5) an individual makes an error in the provision of therapeutic conduct to a vulnerable adult that results in injury or harm, which reasonably requires the care of a physician, and:
(i) the necessary care is provided in a timely fashion as dictated by the condition of the vulnerable adult;

(ii) if after receiving care, the health status of the vulnerable adult can be reasonably expected, as determined by the attending physician, to be restored to the vulnerable adult's preexisting condition;
(iii) the error is not part of a pattern of errors by the individual;
(iv) if in a facility, the error is immediately reported as required under section 626.557, and recorded internally in the facility;
(v) if in a facility, the facility identifies and takes corrective action and implements measures designed to reduce the risk of further occurrence of this error and similar errors; and
(vi) if in a facility, the actions required under items (iv) and (v) are sufficiently documented for review and evaluation by the facility and any applicable licensing, certification, and ombudsman agency.

Vulnerable Adult interviewed: No. Resident was hospitalized.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The resident was transferred to the hospital for an evaluation.

Action taken by the Minnesota Department of Health:
The responsible party will be notified of their right to appeal the maltreatment finding.

The facility was found to be in noncompliance. 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

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

You may also call 651-201-4200 to receive a copy via mail or email

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30641	A. BUILDING: ______ B. WING ______	C 03/31/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE CARE HOMES	**14424 LOWER GUTHRIE COURT APPLE VALLEY, MN 55124**

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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: #HL306419600C / #HL306412620M On March 31, 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 5 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued/orders are issued for #HL306419600C / #HL306412620M, tag identification 1420, 1750, and 2360.	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.	
01420 SS=F	144G.62 Subd. 2 Delegation of assisted living services	01420		

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(b) When the registered nurse or licensed health professional delegates tasks to unlicensed personnel, that person must ensure that prior to the delegation the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each resident and is able to demonstrate the ability to competently follow the procedures and perform the tasks. If the unlicensed personnel has not regularly performed the delegated assisted living task for a period of 24 consecutive months, the unlicensed personnel must demonstrate competency in the task to the registered nurse or appropriate licensed health professional. The registered nurse or licensed health professional must document instructions for the delegated tasks in the resident's record.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to ensure the registered nurse (RN) ensured training and competency demonstrations were completed for unlicensed personnel (ULP)-F before providing suprapubic catheter care and monitoring for symptoms of epilepsy and seizures for R1.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).

The findings include:

R1's service plan indicated R1 received

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suprapubic catheter care and was monitored for symptoms of epilepsy and seizures on each shift (a.m., p.m., and night shift).

ULP-F was hired March 10, 2026, to provide direct care services to the licensee's residents.

ULP-F's training record lacked training and competencies for R1's catheter cares and symptoms of epilepsy and seizures.

The licensee's staff schedule dated March 22, 2026, indicated ULP-F provided unsupervised direct care services, including medication administration to the licensee's residents from 7:00 am to 10:00 p.m.

During an interview on April 1, 2026, at 12:01 p.m., ULP-F stated the first day training on the floor was March 22, 2026, and ULP-F was to shadow another employee. At 8:00 a.m., ULP-F called management to inquire who he would be shadowing as it was his first day working and he was the only staff member at the facility. ULP-F was told by management they were looking for someone to come in and work with ULP-F. ULP-F stated at 9:00 a.m., no other staff came in, so he started breakfast, and worked alone until 9:00 p.m., when the licensed practical nurse (LPN) came in for the night shift.

During an interview on April 1, 2026, at 2:24 p.m., RN-H stated training consisted of a list of things and hands on education. RN-H stated she had procedures, an education list, and competencies she oversaw and completed.

During an interview on April 7, 2026, at 8:25 a.m., ULP-F stated he did not receive hands on training and was not orientated to the computer or

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computer system prior to March 22, 2026. On March 22, 2026, ULP-F stated he performed catheter care on R1. ULP-F stated he had an idea on how to do catheter care as he was a certified nursing assistant (CNA), however, did not know R1 prior to March 22, 2026.

During an interview on April 7, 2026, at 8:46 a.m., ULP-F called the investigator and wanted to clarify again that he did not have access to the computer system, did not have a password to the computer and everything he did that day, he was on the phone with the house manager (AA-D) or the nurse.

The licensee's Delegation of Assisted Living Services policy dated November 14, 2024, indicated when the RN or licensed health professional delegated tasks to unlicensed personnel, that person will ensure that prior to delegation the unlicensed personnel are trained in the proper methods to perform the tasks or procedures for each resident and is able to demonstrate the ability to competently follow the procedures to perform the tasks.

No further information was provided.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days

01750 SS=G 144G.71 Subd. 7 Delegation of medication administration 01750

When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has:
(1) instructed the unlicensed personnel in the proper methods to administer the medications,

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and the unlicensed personnel has demonstrated the ability to competently follow the procedures;
(2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and
(3) communicated with the unlicensed personnel about the individual needs of the resident.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to ensure the registered nurse (RN)-H) instructed unlicensed personnel (ULP)-F) in the proper methods to administer medications for one of one resident (R1), and the unlicensed personnel had failed to demonstrate the ability to competently follow the procedures for administering medications. This had the potential to affect all residents receiving assisted living services.

This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).

The findings include:

ULP-F was hired March 10, 2026, to provide direct care services to the licensee's residents.

The licensee's staff schedule dated March 22, 2026, indicated ULP-F provided unsupervised direct care services, including medication administration to the licensee's residents from

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7:00 am to 10:00 p.m.

ULP-F's employee record indicated the following:
- March 27, 2026, an unlicensed personnel medication administration procedure/competency evaluation was electronically signed by the licensed practical nurse (LPN).
- March 31, 2026, ULP-F completed the Medication Administration - Overview (an online course from an education platform).

ULP-F's record lacked medication administration training and competencies by a registered nurse. Prior to medication administration on March 22, 2026, ULP-F did not receive training on medication administration, medication competencies with a registered nurse, or trained on the licensee's electronic healthcare record (EHR).

During an interview on April 1, 2026, at 12:01 p.m., ULP-F stated the first day of training on the floor was March 22, 2026, and ULP-F was to shadow another employee. At 8:00 a.m., ULP-F called management to inquire who he would be shadowing as it was his first day working and he was the only staff member at the facility. ULP-F was told by management they were looking for someone to come in and work with ULP-F. ULP-F stated at 9:00 a.m., no other staff came in, so he started breakfast, and worked alone until 9:00 p.m., when the licensed practical nurse (LPN) came in for the night shift.

During an interview on April 1, 2026, at 2:24 p.m., RN-H stated training consists of a list of things and hands on education. RN-H states she had procedures, an education list, and competencies she oversaw and completed.

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During an interview on April 7, 2026, at 8:25 a.m., ULP-F stated he did not receive hands on training and was not orientated to the computer or computer system prior to March 22, 2026. On March 22, 2026, ULP-F stated he administered R1's medications, and gave insulin to another resident. ULP-F stated he was told by administrative assistant (AA)-D after administrating medications from the bubble pack (medication prepared by pharmacy and put in punch out cards), AA-D instructed ULP-F to take a photo and send to AA-D. ULP-F stated for the insulin he administered, he called a nurse with the blood sugar reading and administered the insulin.

During an interview on April 7, 2026, at 8:46 a.m., ULP-F stated he wanted to clarify, he did not have access to the computer system, did not have a password, and everything he did that day, he was on the phone with the house manager (AA-D) or the nurse. ULP-F stated "everything I did was with them, and I did not have a password."

The licensee's Medication & Treatments-Administration & Delegation policy dated November 25, 2024, indicated when administration of medications or treatment/therapy is delegated or assigned to a ULP, ensure that the registered nurse has:
- Instructed the ULP in the proper methods with respect to each resident to administer the medications or perform treatment/therapies, and the ULP has demonstrated the ability to competently follow the procedures;
- Specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and
- Communicated with the unlicensed

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01750	Continued From page 7 personnel about the individual needs of the residents. - The ULP must demonstrate their ability to competently follow the delegated medication administration or treatment/therapy to an RN. Written records, signed by an RN, shall be maintained regarding ULP training and competency testing of delegated medication administration and treatment/therapy. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) Days	01750		
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 resident (R1) reviewed was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		