

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL306415422M
Compliance #: HL306412780C

Date Concluded: December 5, 2025

Name, Address, and County of Licensee

Investigated:

Maple Care Homes
14424 Lower Guthrie Court
Appley Valley, MN 55124
Dakota 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) physically abused the resident when he twisted the resident's arm, pushed her into a wall, made her bleed, and called her stupid.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined abuse was substantiated. The AP was responsible for the maltreatment. The AP unreasonably confined the resident. The AP documented in the incident report he closed the resident in an office room and held the door shut. The AP documented in the report hours later the resident pushed his buttons so many times he pushed her in her room and closed the door. The AP documented he physically pushed the resident twice. The AP stated he pushed the resident during an investigative interview.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted a family member of the resident. The investigation included review of the resident records, hospital records, facility internal

investigation, facility incident reports, personnel files, staff schedules, law enforcement report, related facility policy and procedures. Also, the investigator observed staff interaction with residents during an onsite visit.

The resident resided in an assisted living facility. The resident's diagnoses included major depressive disorder, alcohol abuse with alcohol-induced anxiety disorder, and cardiac pacemaker. The resident's service plan included assistance with behavior management of depression and anxiety, and safety checks. The resident's assessment indicated the resident was independent with walking, toileting, medication management, and bathing. The assessment indicated the resident required assistance with arranging transportation.

A facility incident report, authored by the AP, indicated one evening the resident approached the AP upset about being brought to the wrong location for an appointment she had earlier in the day. The report indicated the resident began screaming and yelling at the AP, so the AP closed and held the door shut of the office room he and the resident were in, and the resident grabbed his arm and became aggressive. The report indicated the resident returned to her room and stated she was calling 911. The report indicated approximately four hours later, the resident exited her room and appeared to be packing up personal belongings, and stated she could not stay there. The report indicated the AP put the resident back in her room, and the AP and the resident both called 911. The report indicated law enforcement arrived and spoke to the resident. After speaking with the resident, law enforcement stated the resident was leaving on her bike, and the report indicated the AP stated to law enforcement the resident was not allowed to leave the facility at 3:00 a.m. The report indicated after law enforcement left, the resident continued to pack personal items into the basket of her bicycle, and the AP asked her to return to her room. The report indicated the resident pushed the AP in attempt to move her bicycle. The report indicated the AP removed the resident's items from the basket of the resident's bicycle and placed them back in the resident's room. The report indicated the resident continued to push the AP's buttons many times, so the AP pushed the resident in her room and closed the door. The report indicated the AP pushed the resident in her room twice. The report indicated, two hours later, the resident came out of her room and left the facility via an uber ride.

During an interview, an unlicensed personnel (ULP) stated she was trained on behavior de-escalation, which included staff directive to stay calm, talk to the resident one to one, re-assure the resident, and not say anything back. The ULP stated residents are not allowed to leave the facility late at night. The ULP stated she saw the resident after the incident with the AP, and the resident had scratches on her arms. The ULP stated the resident told her the scratches happened during the altercation with the AP.

During an interview, the administrator stated he was responsible for staff training, and all staff received training on abuse and neglect, resident rights, and mandated reporting. The administrator stated it was a resident's right to leave the facility when they wanted to. The administrator stated staff can refer to a resident's individual abuse prevention plan (IAPP) for

interventions to use when a resident is having behaviors. The administrator stated the AP told him he helped the resident back to her room and helped her to not fall. The administrator stated he felt the AP acted appropriately in the situation and did not think the AP pushed the resident in an abusive manner. The administrator stated the resident did not stay at the facility often because he believed she was avoiding the chemical dependency treatment they attempted to get her in to.

During an interview, the nurse stated the resident's IAPP should include interventions for staff to use for any areas of concern. The nurse stated she expected staff to stay calm, use one to one conversation, offer food, drinks, and as needed medications when a resident had behaviors. The nurse stated the AP called her the night of the altercation between him and the resident, and she directed the AP to ensure his and the resident's safety. The nurse stated she saw a bruise the resident sustained from the altercation, and she recommended it to be checked out. The nurse stated the resident was present at the facility for 41 days and on a bed hold status for 31 days over a two-month period around the time of the incident. The nurse stated the resident was out of the facility frequently due to spending more time with her boyfriend.

During an interview, the AP stated he had never received any disciplinary action while employed for the facility. The AP stated he received training on abuse and neglect, mandated reporting, the staff code of conduct, resident rights, and behavior de-escalation. The AP stated it is a resident right to come and go from the facility as they wanted. The AP stated the resident often drank too much alcohol and became violent, aggressive, and had out of control behavior. The AP stated the evening of the incident, the resident was upset about an appointment she had earlier in the day, and the AP asked her to go into the office with him where he tried to explain to her how the process of setting up a ride for an appointment worked. The AP stated the resident yelled and screamed at him, so he stood up and shut the door in attempt to not wake the other residents from her yelling. The AP stated the resident then got in his face, tapped his face with her finger, so he may have grabbed the resident's arm to move it out of his face. The AP stated he stood by the door after it was closed, but he let the resident out of the room when she wanted to. The AP stated the resident went to her room, and came out yelling and stated he should not work there. The AP stated he called the nurse and asked what he should do, and the nurse stated all he could do was monitor the resident and how she behaved. The AP stated he was the only staff member working that overnight shift, and the resident could go outside, run away, and he had to prevent that from happening. The AP stated he did not want the resident to go outside of the facility in the middle of the night. The AP stated the resident was violent to him when she tried to get her bike out of the garage. The AP stated the resident pushed him around, kicked him, grabbed his arms, and instigated physical abuse to him. The AP stated the resident grabbed his glasses off his face when he told her she could not go outside. The AP stated there was a push and pulling between him and the resident with the resident's room door as he tried to keep her in her room. The AP stated he wanted to keep the resident in her room so she would calm down. The AP stated he worked his shifts as scheduled following the incident with the resident. The AP stated he did not see how his actions could be

seen as abusive since the resident was the one who initiated abusive actions, and he just did self-defense instinctually.

During an interview, a family member stated the resident moved into the facility after she had searched for a facility that was more flexible and allowed for her to have more freedoms. The family member stated he spoke to hospital staff the night of the incident, and they told him the resident had scratches and claw marks on her. The family member stated he spoke to facility staff about the incident, and the staff admitted the incident happened, and the reason the AP grabbed the resident was to prevent her from leaving. The family member stated the facility staff he spoke to apologized for the incident. The family member stated the resident does not feel safe at the facility, so the resident stayed at the facility a day or two, then stayed at friend's home the other days. The family member stated the resident told him she was too anxious during the night since the AP worked the night shift, and she could not get any sleep at the facility. The family member stated he did not believe the AP acted appropriately in the given the situation, and the resident should not have been restrained from leaving when she wanted to. The family member stated he felt the resident was now safe at the facility because new standards were placed for the resident's care for staff to not interfere with the resident's day to day activities.

The resident did not return request for interview.

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;

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.

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.

(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 a sudden event.

Vulnerable Adult interviewed: No, did not return request for interview.

Family/Responsible Party interviewed: Yes.

Alleged Perpetrator interviewed: Yes.

Action taken by facility:

The facility provided appropriated training to staff on abuse and neglect.

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 Board of Nursing

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30641	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/10/2025
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NAME OF PROVIDER OR SUPPLIER MAPLE CARE HOMES	STREET ADDRESS, CITY, STATE, ZIP CODE 14424 LOWER GUTHRIE COURT 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>HL306412780C/HL306415422M</p> <p>On November 10, 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 5 residents receiving services under the provider's Assisted Living with Dementia Care license.</p> <p>The following correction order is issued for HL306412780C/HL306415422M, tag identification 2360.</p>	0 000	<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>	
02360	<p>144G.91 Subd. 8 Freedom from maltreatment</p> <p>Residents have the right to be free from physical,</p>	02360		

Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30641	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/10/2025
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NAME OF PROVIDER OR SUPPLIER MAPLE CARE HOMES	STREET ADDRESS, CITY, STATE, ZIP CODE 14424 LOWER GUTHRIE COURT APPLE VALLEY, MN 55124
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02360	<p>Continued From page 1</p> <p>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		