*Protecting, Maintaining and Improving the Health of All Minnesotans*

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** HL333768882M
**Compliance #:** HL333766761C

**Date Concluded:** May 16, 2025

**Name, Address, and County of Licensee Investigated:**
Maple Care Homes
1209 East 131st street
Burnsville, MN 55337
Dakota County

**Facility Type:** Assisted Living Facility (ALF)

**Evaluator's Name:** Erin Johnson-Crosby, RN
Special Investigator

**Finding:** Not Substantiated

**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 staff failed to supervise the resident and staff were not aware of the resident's location for weeks.

**Investigative Findings and Conclusion:**
The Minnesota Department of Health determined neglect was not substantiated. The resident was able to leave the facility independently and without supervision and staff were aware of the resident's location.

The investigator conducted interviews with facility staff members, including administrative staff and unlicensed staff. The investigator contacted the resident's case worker. The investigation included review of resident and facility records, 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 facility. The resident's diagnoses included autism, substance abuse disorder, and depression. The resident's service plan included assistance with medication administration, dressing, grooming, safety checks, and behavior management. The resident's assessment indicated the resident could come and go from the facility, but the resident was to sign out and tell staff where she was going.

The resident's medical record indicated the resident went to a family member's house and service notes indicated services were not completed since the resident was out of facility. The resident's discharge assessment indicated the resident was alert and oriented when she voluntarily left the facility and did not return.

During an interview, the resident's case manager (CM) stated the resident was able to come and go freely and was very independent. After the resident left the facility, she spent time at the family member/guardian's house, detox facilities, and sober houses. The CM stated the resident's family was always in contact with the resident and contacted the facility regarding the resident's location. The CM was not concerned about supervision of the resident while she lived at the facility.

During an interview, management staff stated the resident left the facility when the resident's family brought the resident to detox. Later, staff were informed the resident was not at detox but with the family/guardian. The resident was able to leave the facility independently. The resident's family/guardian kept facility staff updated regarding the resident's location.

During an interview, the resident's family/guardian stated she brought the resident to a detox facility for an assessment and believed she would be admitted for 90 days; however, the resident was not accepted. The family stated the resident lived in between their house, the facility, and the resident's boyfriend's house and eventually discharged from the facility. The resident was also in detox twice during this time.  The family stated the facility was aware of the resident's location and the resident was able to leave the facility independently.

In conclusion, the Minnesota Department of Health determined neglect was not substantiated.

**"Not Substantiated" means:**
An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment did not occur.

**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.

**Vulnerable Adult interviewed**: No, attempted but did not reach.
**Family/Responsible Party interviewed**: Yes
**Alleged Perpetrator interviewed**: Not Applicable

**Action taken by facility:**
No action taken.

**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 |
|---|---|---|---|
| | 33376 | A. BUILDING: _____ B. WING _____ | C 04/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MAPLE CARE HOMES | 1209 EAST 131ST STREET BURNSVILLE, MN 55337 |

| (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<br><br>On April 18, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL333766761C/#HL333768882M. No correction orders are issued. | 0 000 | | |