Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL339753702M
Compliance #: HL339757148C

Date Concluded: July 22, 2025

Name, Address, and County of Licensee Investigated:
Maple Woods Assisted Living
33310 State Highway 6
Deer River, MN 56636
Itasca County

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

Evaluator's Name:
Katherine Barnhardt, 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 facility staff failed to provide supervision and prevent the resident's elopements.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The resident had a history of aggressive behavior and walking away from medical facilities prior to elopements that occurred at the assisted living facility. The facility coordinated with behavioral health providers, family and law enforcement to manage the resident's elopements.

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 record(s), hospital records, pharmacy records, facility internal investigation, facility incident reports, personnel files, staff

schedules, law enforcement report, related facility policy and procedures. Also, the investigator observed facility staff provide direct cares.

The resident resided in an assisted living memory care unit. The resident's diagnoses included moderate dementia and psychotic disturbance. The resident's service plan included assistance with behavior management, safety checks and supervision. The resident's assessment indicated the resident was independent with activities of daily living, walked frequently, was impulsive and had poor judgement. The assessment indicated the resident had a history of substance abuse, was an elopement risk and had successfully eloped from facilities.

The resident's record indicated the facility was aware of the resident's risk for elopements and incident reports outlined how the resident eloped. The resident eloped seven times from the facility's secure unit and made several unsuccessful attempts. The facility requested behavioral health assistance, and a provider adjusted behavioral health medications. Facility staff allowed the resident to spend time in an area of the facility secured by an eight-foot fence when the resident was not displaying exit seeking behaviors. Facility staff were aware the resident could climb the fence and planned the resident's time outside to be monitored by facility staff. Two of the elopements occurred when facility staff were present and unsuccessfully attempted to redirect the resident away from the fence. Facility staff alerted authorities when the resident left facility grounds. The resident's family had installed a Life360 location application on the resident's cell phone and family had the ability to locate the resident when he eloped. Each time the resident eloped he was returned to the facility by law enforcement or family unharmed.

The resident's incident reports indicated the resident had witnessed and unwitnessed elopements. The resident had a history of aggression with facility staff and family when he wanted to leave, and the resident had used furniture to climb a fence in a secured outside area. The facility held a care conference with family, a resident representative and consulted with law enforcement to develop a safety plan for the resident. The facility and law enforcement coordinated with the family to monitor, locate and return the resident to the facility with a Life360 cell phone application installed on the resident's phone.

Law enforcement reports indicated the resident had walked away from medical facilities prior to placement in the facility. Officers had been called to assist in locating and returning the resident to the facility four times in two months. Facility staff and management were in contact with law enforcement officers throughout the resident's elopements and at times facility staff had eyes on the resident while waiting for officer assistance.

During an interview, a licensed staff stated the resident resided in a secured area of the facility and like to spend time outside. Licensed staff stated the resident had eloped from the facility and would go to a place he was familiar with in his younger years. Licensed staff stated coordination with the resident's family and law enforcement was put in place to keep the resident safe when he eloped. Licensed staff stated the resident was difficult for staff to

redirect until the facility reached out to behavioral health for assistance. Licensed staff stated behavioral health assessed the resident for the best interventions to manage the resident's behaviors and a neuropsychic evaluation was scheduled. Licensed staff stated since behavioral health became involved, and facility staff became familiar with the resident's preferences the resident was more content and one to one supervision was provided when the resident was outside in the secured area.

During an interview, a resident representative stated the resident could scale a secured fence in the outside area and facility staff "can't physically pull him off the fence" or stop the resident when he made up his mind to leave. A resident representative stated interventions were implemented and family was involved. A resident representative stated the resident likes it there and was settling in.

During an interview, a family member stated the resident could be very difficult, however, thought the facility was trying their best to manage and prevent the resident's elopements. A family member stated the resident could scale an eight-foot secured fence when he wanted to leave the facility and liked to be outside. A family member stated the facility, and family had attempted to have the resident transferred to a specialized behavioral facility for evaluation, but the behavioral facility would not accept the resident due to medical concerns.

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
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
The facility implemented a variety of interventions and coordinated with outside agencies to provide a safety plan for the resident.

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
	33975	A. BUILDING: _____ B. WING _____	C 07/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE WOODS ASSISTED LIVING	33310 STATE HIGHWAY 6 DEER RIVER, MN 56636

(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: #HL339753665M/ #HL339757051C #HL339753702M /#HL339757148C On July 8, 2025, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction order is issued. At the time of the complaint investigation, there were 21 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL339753665M/ #HL339757051C, tag identification 2360.	0 000	Assisted Living Provider 144G. 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 resident(s) 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		