Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL374378803M
Compliance #: HL374376542C

Date Concluded: May 14, 2025

Name, Address, and County of Licensee Investigated:
Maple Care Homes
8997 Montegue Terrace
Brooklyn Park, MN 55443
Hennepin County

Facility Type: Assisted Living Facility (ALF)

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 she slapped the resident in the face.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was substantiated. The AP was responsible for the maltreatment. There was a preponderance of evidence the AP slapped or hit the resident in the face after the resident dropped the AP's phone on the floor, which caused the resident to lose his balance and fall to the floor. A second staff member stated she witnessed the AP hit the resident. The resident had a mark on his face.

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

files, staff schedules, video footage, and related facility policy and procedures. Also, the investigator observed staff and resident interactions while on site.

The resident resided in an assisted living facility. The resident's diagnoses included severe intellectual disability, dementia and anxiety. The resident's service plan included assistance with medication administration, and supervision by staff. The resident's assessment indicated the resident was nonverbal and used gestures for communication. The assessment indicated the resident was independent with walking and frequently refused to use a walker for assistance as recommended.

A facility incident report indicated an unlicensed personnel (ULP) reported the AP physically attacked the resident when attempting to take her phone from the resident. The resident lost his balance and fell to the floor. The report indicated the licensed assisted living director (LALD) reviewed facility camera footage of the incident, and it was determined the AP maltreated the resident. The LALD terminated the AP's employment at the facility immediately.

The facility provided video footage observed by the investigator showed the resident falling to the floor. Although the action of the AP was not in view, the audio heard the ULP loudly stating in a tone of concern "No [name of AP], No, why you do that, you can't do that." The video showed the resident getting himself off the floor and sitting on a couch in the living room.

During an interview, the ULP stated she witnessed physical abuse of the resident by the AP. The ULP stated she entered the facility with shopping bags in her hands when she noted the AP to be in the kitchen talking to someone using an earpiece. The ULP stated she saw the resident pick up the AP's phone that was on a chair in the living room and drop it. The AP rushed toward the resident and hit the resident in his face, and the resident fell. The ULP stated she was not sure if the AP pushed the resident down. The ULP stated she screamed at the AP "no don't do that, why would you do that? I saw it all!" The ULP stated she was not sure if the AP hit the resident with a fist or an open hand, but she saw the motion of her hand contact his face. The ULP stated after the AP was instructed by the LALD to leave the facility. The AP called her and stated she was sorry, that she did not know what had come over her and was hoping she would not be in trouble. The ULP stated the AP admitted to her she had hit the resident.

During an interview, the LALD stated the ULP called him and stated the AP had physically abused the resident. The LALD stated the ULP was upset, and he could hear serious concern in her voice. The LALD stated he immediately went to the facility, and when he arrived, he noted the resident to be crying, holding his face and pointing at the AP. The LALD stated he asked the AP what happened, and she said nothing happened. The LALD stated he asked her again what happened and told the AP he had video footage of the incident. The LALD stated the AP then told him the resident dropped her phone while she was in the kitchen, she picked up the phone, and when she went to help the resident sit back down, he fell. The LALD stated he saw a small area between the resident's chin line and neck that was marked and slightly swollen. The LALD stated he showed the AP the mark on the resident and instructed the AP to leave the facility.

The LALD stated he spoke to the ULP and asked her what happened. The LALD stated the ULP told him the resident picked up the AP's phone and dropped it. The AP then rushed to the resident to punch at him, and he fell to the floor. The LALD stated the AP called him after he instructed her to leave the facility. The LALD stated the AP apologized, said she was sorry and denied harming the resident. The LALD stated he reiterated to the AP the proof was there that she abused the resident. The LALD stated the ULP received threatening calls from the AP since the incident, making the ULP feel unsafe and wanting to resign from her position.

During an interview, the AP stated she received proper training about the abuse and neglect of residents. The AP stated the resident took her phone and chucked it. The AP stated she picked up her phone and asked the resident why he did that. The AP stated she went back to the kitchen and then the resident was on the floor, after he had been trying to go back to his chair. The AP stated the LALD arrived at the facility and asked her what happened, and she told him she did not do anything to the resident. The AP stated she heard the resident fall, and when she went to him, he had already gotten himself up and in the chair. The AP stated she checked the resident for any injury, and she saw nothing on the resident. The AP stated if she had slapped the resident, there would have been a mark on him.

During an interview, a family member stated he did not have concerns about the resident's well being while he resided at the facility. The family member stated he did not see any change of negative effect to the resident after the incident, and he felt the resident was safe at the facility.

The resident was nonverbal and unable to complete an 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;

(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.

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 not a sudden or foreseen event.

Vulnerable Adult interviewed: No, the resident was non verbal.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The AP was no longer employed at the facility.

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
Hennepin County Attorney
Brooklyn Park City Attorney
Brooklyn Park Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37437	A. BUILDING: _____ B. WING _____	C 04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE CARE HOMES	8997 MONTEQUE TERRACE BROOKLYN CENTER, MN 55443

(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, section144G.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: #HL374376542C/#HL374378803M On April 30, 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 Comprehensive Assisted Living license. The following correction order is issued/orders are issued for #HL374376542C/#HL374378803M, tag identification 2360.	0 000		
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	02360		

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02360	Continued From page 1 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	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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