Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL374379762M
Compliance #: HL374374242C

Date Concluded: June 26, 2026

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

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Kris Detsch RN
Special Investigator
Rhylee Gilb, RN
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 alleged perpetrator (unknown staff member) abused the resident when they caused a laceration and swelling to the resident's eye. Additionally, the facility neglected the resident when they delayed obtaining medical care.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. Although it could not be determined how the resident sustained the injury, it was determined systemic facility errors caused a delay in obtaining medical care. There were conflicting accounts from staff members about how and when the injury occurred, however the facility staff failed to report the injury to leadership. The extent of the resident's injuries was discovered when a manager went to the facility and saw the resident had swelling around his right eye and a laceration which required medical intervention. The

resident went to the emergency room (ER), received closure of the laceration and evaluation for further head injuries. The facility failed to address the resident's mobility issues and crawling with safety interventions, leaving him susceptible to injuries.

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 internal investigation, facility incident reports, personnel files, and related facility policy and procedures. Also, the investigator toured the facility and observed medication administration, documentation systems, and staffing levels.

The resident resided in an assisted living facility. The resident's diagnoses included severe intellectual disability, dementia, mood disorder, and right eye disorder. The resident's service plan included assistance with walking, bathing, dressing, grooming, toileting, medications, and behavior management. The resident's nursing assessment indicated he could not talk but used some "gestures" to communicate his needs. The resident's right leg was shorter than his left leg and he had a shuffling gait. The resident was unable to stand upright because his knees were always in a "bent" position. The resident had a history of falling.

A facility incident report indicated unlicensed personnel (ULP) #1 went to the downstairs area of the facility in the late afternoon and found the resident on the floor with a cut on his forehead. ULP #1 provided first aide treatment and texted the nurse about the incident. The report specified the date and time the ULP #1 alerted the nurse. (This was one day before the resident went to the hospital). The nurse reviewed the incident report and added more information onto the same report. Her documentation indicated another staff member (the manager) went to the facility the day after the incident and discovered the resident's injuries were more serious than ULP #1 initially described. The nurse's documentation indicated the resident's wound appeared to need stitches (closure), and he had increased swelling of his right eye. The facility called the paramedics, and they took the resident to the hospital.

Hospital records indicated the resident arrived at the emergency room (ER) late in the afternoon by ambulance. The records indicated the facility told the paramedics the resident had a previous laceration on his right eyebrow, but the swelling and bruising were new. The facility provided emergency responders with conflicting accounts of how the resident sustained these injuries. Initially, the facility staff told the paramedics another resident assaulted him, however, the facility then said he fell. The record indicated when paramedics asked the resident what happened today, the resident made fists and pointed to his right eye. The hospital completed various diagnostic testing to determine the extent of the resident's injuries due to the unclear circumstances. The resident's lab work was normal for no clinical cause of the right eye swelling and bruising and no acute brain injury or fractures. The physician noted a concern the resident may have been punched. The resident returned to the facility in the evening.

A correspondence between the Minnesota Department of Health and the facility director two weeks after the incident, indicated the facility director reported the facility was monitored with

cameras. The facility director indicated they reviewed the camera footage and did not see the (alleged) fall.
During an onsite observation, the investigator observed the resident crawling on the basement floor. The resident had crawled to a narrow hallway and was banging on the door of another resident's (resident #2) room. Due to laying on the ground and crawling in the confined area, if resident #2 tried to leave his room with the resident hitting at his door, the resident would be susceptible to being kicked, whether intentionally or accidentally.

Resident #2's medical record indicated occasionally he drinks alcohol and while under the influence can be verbally and physically aggressive. Interventions directed staff to remove other residents from the situation and avoid engaging with resident #2 to reduce escalation.

During an interview, resident #2 stated the resident has tried to hit him a couple of times, bangs on his door and grabs at his legs when he is walking by. Resident #2 stated he tries to ignore him.

During an interview, the nurse said the fall occurred the day before the resident went to the hospital. The nurse said she received a text message from ULP #1 who informed her the resident fell, and he had a cut on his forehead. The nurse said ULP #1 sent her the text message in the afternoon; however, she did not read the text message until late in the night. The nurse said she attempted to call the facility, but could not get ahold of a staff member, so she planned on going to the facility the following day. The nurse said a manager went to the facility the next day and told her about the resident's injury. The nurse said the resident went to the hospital.

During an interview, a manager said a staff member called her and told her the resident had a "cut" so she went to the facility. The staff member told her they found the resident on the floor (unwitnessed fall). The manager said she sent the resident to the hospital. The manager said this fall incident happened on the same day she sent the resident to the hospital. The manager said after this incident, she watched video footage and discovered the resident was in the lounge area of the lower level of the facility in the late night/early morning and fell onto his forehead. (This occurred on the same day the resident to the hospital). When asked about the conflicting dates of the incident, the manager said the staff member could have put the wrong date on the incident report, or there could have been two separate incidences.

During an interview, ULP #1 said he arrived to work in the morning, checked on the resident, and gave him breakfast and medications. Then, the resident went back to his room (lower level) to take a nap. ULP #1 said he checked on the resident about an hour later and found the resident on the ground with a bruise on his head. ULP #1 said he called the nurse and told her about this. ULP #1 said the manager and the nurse went to the facility and sent the resident to the hospital. ULP #1 said this event occurred in the later morning hours. ULP #1 said the resident went to the hospital on the same day the fall occurred.

During an interview, a director said the resident was physically combative and had a mood disorder. The director said the resident could not talk, but made noises/screaming sounds. The resident's behavior included crawling on the floor, and he used objects to hit himself which could have caused the injury, not necessarily a fall.

Progress notes described the same information as ULP #1 documented in the incident report; however, the dates did not align. The date in the progress note was one day after the date on the incident report. Progress notes lacked any information or description about the fall event as described by the manager during the late night/early morning as she observed by video footage. Staff members who worked during the night shift and day shift would have seen the resident's injuries before the afternoon he went to the hospital, but their interviews and progress notes did not reflect this.

The resident's care plan/service plan lacked updated safety and fall risk interventions to address the resident's mobility and crawling on the floor. The resident's assessments remained unchanged from prior to the fall.

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.

Vulnerable Adult interviewed: No. Unable to participate.
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:
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
Hennepin County Attorney
Minneapolis City Attorney
Minneapolis Police Department
Minnesota Board of Executives for Long Term Services and Supports
Minnesota Board of Nursing

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 05/20/2026

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, 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: HL374374242C/HL374379762M On May 20, 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 five residents receiving services under the provider's Assisted Living license. The following correction orders are issued for HL374374242C/HL374379762M, tag identification 2310, 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.	
02310 SS=G	144G.91 Subd. 4 (a) Appropriate care and services	02310		

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02310	Continued From page 1 (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to implement appropriate and up-to-date nursing interventions to meet the mobility needs for one of one resident (R1) with record reviewed. The licensee failed to obtain therapy evaluations and adaptive/protective equipment to protect R1 from injury. The licensee allowed R1 to crawl on his hands and knees on the linoleum floors (un-padded). As a result, R1 continued to have falls and skin injuries. This practice resulted in a level four violation (a violation that harmed a resident ' s health or safety, not including serious injury or death, or a violation that was likely to lead to serious injury or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1's diagnoses included severe intellectual disability, dementia, mood disorder, and right eye disorder. R1's service plan dated March 31, 2023, indicated R1 required assistance with ambulation, bathing, dressing, grooming, toileting and behavior management. R1's nursing assessment dated December 17,	02310		

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02310	Continued From page 2 2025, indicated R1's right leg was shorter than his left leg and it was recommended (by "who" not identified) he used a walker at all times. The assessment indicated R1 had a shuffling gait, and he was unable to stand upright. R1's knees were always "bent" when he walked. The assessment indicated R1 had 2+ pitting edema in both his ankles and swelling of his right eyelid. The assessment indicated R1 had a history of falling. The assessment indicated R1's lower extremity muscle coordination decreased, and he had increased difficulties walking. R1 had scab areas and skin tears on both of his shins from bumping into walls and stairs. The assessment indicated the licensee would continue to "monitor" and provide first aide as needed. The assessment indicated an evaluation by physical therapy (PT) was recommended (by "who" not identified) and the licensee's management would "follow up." The assessment failed in identify R1 crawled around on the floor. The assessment indicated a mental health physician evaluated R1's mental health medications on September 19, 2025. The licensee failed to coordinate a PT evaluation for R1. Incident report dated January 11, 2026, at 1:50 p.m., indicated unlicensed personnel (ULP)-C went downstairs at 2:50 p.m. and saw R1 on the floor with a cut on his forehead. ULP-C provided first aide treatment and texted the nurse about the incident. The incident report indicated R1 went to the hospital the following day because the head injury appeared to be a bit more serious than ULP-C described. The report indicated another staff member (name not identified) observed R1's injury and thought he needed stitches to the wound. This staff member also observed increased swelling in R1's right eye.	02310		

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02310	Continued From page 3 The incident report indicated registered nurse (RN)-B reviewed this information and she documented R1 had increased difficulties walking and crawled to climb the stairs, or roll out of bed onto the floor. RN-B indicated R1 bumped into objects and had scrapes and small skin tears on his shins from bumping into objects. Hospital records dated January 12, 2026, indicated R1 went to the emergency room (ER) due to head injuries. R1 had a laceration on his right eyebrow and swelling around his right eye. The cause and circumstances of these injuries were unknown by facility staff. The records indicated the hospital performed diagnostic testing including knee x-rays. The test results indicated R1 did not have any fractures to his knees, but he did have soft tissue swelling. Incident report dated January 19, 2026, at 6:00 p.m., indicated a staff member observed R1 lying in his bed with blood on the chux (pad) underneath him. The staff member shaved R1's hair for a better view of the wound. The staff member cleansed the wound and applied an antibiotic ointment. The incident report contained a picture diagram of the wound, but indicated the wound on was the right side of the back of R1's head. The report failed to include the size, or further description of the wound. The report indicated R1 continued to have difficulties walking and an even harder time climbing the stairs without assistance. R1's record lacked an assessment of R1's head laceration and an evaluation of R1's mobility and falls to implement new interventions. R1's nursing assessment dated March 17, 2026, indicated the assessment was a 90-day	02310		

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02310	Continued From page 4 assessment. The assessment indicated the licensee made no major changes to R1's plan of care. The assessment contained the same information as the previous nursing assessment dated December 17, 2025, including the statement regarding physical therapy evaluation. The assessment failed to include fall and safety interventions to reduce injury for R1. Hospital records dated May 10, 2026, indicated R1 went to the emergency room (ER) because he fell. This fall was unwitnessed by the licensee's staff members, but they heard the fall occur and checked on him. Hospital records indicated the licensee's staff told them R1 walked with a walker, but was unsteady and fell frequently. Hospital records indicated a physician spoke to the licensee's staff about R1's falling and suggested he use a wheelchair. Hospital records indicated they evaluated R1 for head injuries and returned him to the licensee. R1's record lacked documentation of attempting to aquire a wheelchair for R1 to use, failed to include a post fall and emergency room visit assessment and failed include new fall interventions. On May 20, 2026, at 7:50 a.m., the surveyor observed R1 in his room. The surveyor observed R1 crawling on the linoleum bare floor on his hands and knees. R1 wore dark blue shorts, a blue shirt, and dark grey gripper socks. The surveyor observed R1 crawl around the hallway of the lower level of the licensee's facility. The surveyor observed R1 pull himself up to a standing position by holding onto a door frame. R1 appeared to have contractures of his knees and could not fully extend his legs. R1 appeared to have contractures of his hands and could not	02310		

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02310	Continued From page 5 fully extend his hands/fingers. The surveyor observed callous areas, and dark skin discoloration of R1's kneecaps. The surveyor did not observe any skin protective devices such as kneepads, or floor pads. The surveyor did not observe any adaptive/protective devices for contractures. On May 20, 2026, at 7:50 a.m., ULP-I said R1 gets down on the ground himself and "crawls" around on the floor. ULP- I said the licensee does not allow him to have a walker downstairs (in his room). ULP -I said R1 did not have a wheelchair. On May 26, 2026, at 12:26 p.m., administrator (A)-A said R1 was dependent upon staff for all cares. A-A said R1 could not talk but would on occasion use "hand gestures" for communication. A-A said R1 could not walk well and initially used a cane, but then used a walker. A-A said R1 declined to use a wheelchair. A-A said R1 was physically aggressive and combative with staff and other residents. A-A said R1 crawled around, so the licensee removed all items from his room (other than clothing and bed). On May 26, 2026, at 3:06 p.m., RN-B said R1 was non-verbal and had developmental delay. R1 occasionally used sign language/gestures. R1 required assistance with all activities of daily living (ADL). R1 had physical aggression and combative behavior. RN-B said PT has not evaluated R1. RN-B said manager (M)-D was supposed to be working on obtaining the PT evaluation. RN-B said R1 did not have a wheelchair, and they (licensee) were trying to talk with R1's physician about getting him one. RN-B acknowledged R1 had nothing in place to protect his limbs as he crawled on the floor.	02310		

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02310	Continued From page 6 On May 26, 2026, at 2:03 p.m., M-D said she was currently working on obtaining a PT referral from R1's physician. M-D said R1 did not have a wheelchair. M-D said R1 was using his walker more often, but refused to use it at times. M-D said the licensee was planning to move R1 from the lower level to a room on the main level. On June 1, 2026, at 1:52 p.m. the surveyor requested (via email) the licensee's policy for medications/treatments, vulnerable adult, falls, incidents, and nursing assessments. No policies received. Time period for correction: Seven (7) days.	02310		
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 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		