

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL213873246M
Compliance #: HL213872507C

Date Concluded: August 24, 2026

Name, Address, and County of Licensee

Investigated:

Rose Arbor & Magnolia Trails
16500 92nd Ave N
Maple Grove, MN 55311
Hennepin County

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

Evaluator's Name:

Jana Wegener, 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 resident was neglected when the facility failed to ensure assistance with new dentures and oral care was provided causing epulis (an overgrowth of tissue) bleeding, sores, and pain.

Investigative Findings and Conclusion: The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. Although the facility was aware the resident was dependent on staff for oral cares, they failed to ensure the service plan of care provided instructions for staff to assist/monitor the resident after he received a new partial denture prosthesis. About two months later, the resident had developed epulis around his partial denture from it not being removed for a prolonged period of time causing pain, heavy bleeding, and sores to develop spanning the floor of the resident's mouth in the shape of the partial denture.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's guardian, family,

and provider. The investigation included a review of the resident records, staff schedules, related facility policy and procedures, and outside medical/dental records and photographs. Also, the investigator observed residents and staff in the secured memory care unit.

The resident resided in an assisted living secure memory care unit with diagnoses including age related debility, dementia, and schizoaffective disorder.

Dental records indicated a concern arose when the resident developed epulis tissue overgrowth, with pain, heavy bleeding, and sores spanning the floor of the resident's mouth in the shape of the partial denture from the denture not being removed for a prolonged time.

The resident's assessment and service plan of care at the time indicated the resident required full assistance with morning and bedtime grooming including oral care. The assessment and service plan of care indicated the resident was in the process of getting new dentures and would require staff assistance with management.

Approximately 2 months prior, a dental after visit summary (AVS) indicated the resident received new dentures with instructions for adjusting to and caring for the new dentures. The instructions indicated sore spots could develop and staff should monitor for and allow the resident to take breaks throughout the day but not stop wearing them. The AVS indicated staff should provide saltwater rinses if soreness developed. The AVS indicated staff should remove the dentures, clean them, let them soak, and brush the resident's teeth and gums after eating.

Two weeks after receiving the new dentures the resident was seen by the dentist again. The AVS from this visit indicated the resident was seen for a denture follow up and adjustment. The AVS indicated if sores or soreness developed from the new dentures the resident should take breaks (2 hours in, 2 hours out) with saltwater rinses to soothe his gums as needed. The AVS indicated staff should provide direct assistance with inserting and removing the dentures daily because the resident was unable to do so on his own. The same day a dental progress note indicated a facility staff member (staff #1) who accompanied the resident during the appointment reported staff were having difficulty inserting and removing the resident's partial denture. The note indicated adjustments to the partial were made, and staff #1 took a video for the facility to provide instructions for staff on how to assist the resident to insert and remove the partial denture.

A review of the resident's record including assessment, service plan of care, and documentation of services provided did not identify the facility provided specific instructions as ordered in the dental AVS to assist the resident with his new denture/partial denture including inserting and removing the dentures, brushing his teeth and gums after meals, monitoring for soreness, or providing saltwater rinses if soreness developed as ordered.

Two months after initially receiving the new dentures, the dentist again saw the resident. The AVS and dental providers progress note indicated when the resident had heavy oral food debris

noted. Upon removal of the resident's lower partial denture a "suction" noise was heard and the resident expressed pain upon removal. The AVS and dental providers progress note indicated heavy bleeding was noted when the partial denture was removed and the resident had a large U-shaped sore on the floor of his mouth with epulis present on gingival tissues that were red and bulbous (bulging swollen), which indicated the resident's partial denture had been in his mouth for a pro-longed period of time. The AVS and dental providers progress note again indicated the resident was dependent on the facility for care and unable to insert and remove the dentures on his own. The AVS included orders for warm saltwater rinses twice per day for the next 7 days for wound care.

Dental images taken at the time the epulis was identified showed swelling, redness, and bleeding in the shape of the partial denture spanning the base of the resident's mouth as documented in the AVS and dental providers progress note.

During an interview, unlicensed caregiver #1 stated they accompanied the resident to follow up dental appointments. Unlicensed caregiver #1 stated the facility was aware the resident required assistance with oral and denture care including inserting and removing the partial denture because unlicensed caregiver #1 had given the dental AVS's and video instructions to facility leadership. Unlicensed caregiver #1 stated they were "horrified" when the resident developed sores and bleeding from staff not removing the partial denture.

During an interview, unlicensed caregiver #2 stated she provided the resident assistance with brushing his teeth but was not aware the resident had a partial denture, dentures, or missing teeth.

During an interview, unlicensed caregiver #3 stated she had brushed all the resident's teeth as a standard of care morning and at bedtime but did not recall the resident had dentures/partial dentures or needed assistance to insert or remove them.

During an interview, unlicensed caregiver #4 indicated she did not know the resident had dentures or needed assistance with inserting or removing them.

During an interview, unlicensed caregiver #5 stated she brushed the resident's teeth but thought the resident had his own teeth and did not recall receiving instruction to insert or remove the resident's dentures.

During an interview, a licensed nurse stated she was not aware the resident had new dentures, or issues with staff inserting or taking the dentures out.

When interviewed and during email communication facility leadership denied being aware staff had not provided dental care and services including assistance with inserting, removing, or oral hygiene. Leadership denied receiving orders/instructions regarding the resident's denture/partial denture care until after bleeding, sores, and epulis developed. Leadership

indicated they had no documentation to show denture or oral care, and services were implemented or provided by staff at the time the incident occurred.

During an interview, the resident's dental provider stated some challenges and soreness with new dentures were expected, and instructions for care and monitoring were provided to the facility which she expected them to implement. The provider indicated the resident was cognitively impaired and dependent on staff assistance with denture and oral care. The provider stated a video of the partial insertion and removal process was obtained by unlicensed caregiver #1 to ensure all staff understood how to insert and remove the resident's dentures. The provider stated during the initial follow up the resident had no sores, and instructions again were provided to assist the resident with inserting, removing the dentures, and monitoring for soreness. Then, about two months later the resident had developed epulis a tissue overgrowth caused by continuous wearing of denture over a prolonged period of time (usually months). The provider stated the epulis overgrowth was an indication the partial likely never left the resident's mouth. The provider stated when the partial was removed a loud suction noise was heard which was not normal and the resident had heavy bleeding, large sores spanning the floor of his mouth in the shape of the partial, and severe pain. The provider stated in her professional opinion what she observed (epulis, sores, bleeding, and pain) was from having the partial being in the resident's mouth for far too long and prolonged neglect of care. The provider indicated due to the uncertainty facility staff would consistently provide denture and oral care as ordered, it was safer for the resident not wear his dentures due to the risk of recurring epulis, sores, bleeding which would put the resident at risk for complications like infection or additional tooth loss.

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, not available for interview.

Family/Responsible Party interviewed: Yes

Alleged Perpetrator interviewed: N/A

Action taken by facility: After the resident developed sores, bleeding, pain, and epulis the facility implemented orders for oral hygiene, and saltwater rinses. The resident's sores healed.

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

Maple Grove City Attorney

Maple Grove Police Department

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21387	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/13/2026
NAME OF PROVIDER OR SUPPLIER ROSE ARBOR/WILDFLOWER LODGE			STREET ADDRESS, CITY, STATE, ZIP CODE 16500 92ND AVENUE NORTH MAPLE GROVE, MN 55311		
(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***** HOME CARE PROVIDER/ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, 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: #HL213873246M/#HL213872507C On July 13, 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 74 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued/orders are issued for #HL213873246M/#HL213872507C, tag identification 0450, 1650, and 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.		
0 450 SS=G	144G.41 Subdivision 1 Minimum requirements All assisted living facilities shall:	0 450			

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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0 450	Continued From page 1 (1) distribute to residents the assisted living bill of rights; (2) provide services in a manner that complies with the Nurse Practice Act in sections 148.171 to 148.285; (3) utilize a person-centered planning and service delivery process; (4) have and maintain a system for delegation of health care activities to unlicensed personnel by a registered nurse, including supervision and evaluation of the delegated activities as required by the Nurse Practice Act in sections 148.171 to 148.285; This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to utilize person centered planning and service delivery processes to ensure delegation and supervision for activities of daily living was provided as ordered for one resident (R1) reviewed for maltreatment. R1 was harmed when the licensee failed to delegate instructions for insertion and removal, oral care, and monitoring for soreness, after R1 received new partial dentures. R1 developed sores, bleeding, and epulis (an overgrowth of tissue) from the partial not being removed for a prolonged period of time. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, 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).	0 450			

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0 450	Continued From page 2 Findings include: The Nurse Practice Act indicated the definition of "delegation" means the transfer of authority to another nurse or competent, unlicensed assistive person to perform a specific nursing task or activity in a specific situation. The National Guidelines for Nursing Delegation, developed by the American Nurses Association (ANA) effective April 29, 2019, indicated the licensed nurse cannot delegate nursing judgement or any activity that will involve nursing judgement or critical decision making. The same document indicated the five rights for delegation included the right directions and communication which indicated each delegation situation should be specific to the patient, the licensed nurse and the delegatee. This communication includes any data that need to be collected, the method for collecting the data, the time for reporting the results to the licensed nurse, and additional information pertinent to the situation. The licensed nurse is responsible for monitoring the delegated activity, following up with the delegatee at the completion of the activity, and evaluating patient outcomes. R1 was admitted to the assisted living secure memory care unit on September 28, 2021, with diagnoses including age related debility, dementia, and schizoaffective disorder. R1's comprehensive quarterly assessment and service plan of care dated February 24, 2026, indicated R1 required full assistance with morning and bedtime grooming/hygiene assistance which included shaving, oral care, and deodorant. The assessment and service plan of care indicated R1 was in the process of getting new dentures and would require staff assistance with management.	0 450			

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0 450	Continued From page 3 On March 11, 2026, a dental after visit summary (AVS) indicated R1 received his new dentures with instructions for adjusting to and caring for the new dentures. The instructions indicated sore spots could develop and staff should monitor for and allow R1 to take breaks throughout the day but not stop wearing them. The AVS indicated staff should provide saltwater rinses if soreness developed. The AVS indicated staff should remove the dentures, clean them, let them soak, and brush R1's teeth and gums after eating. On March 24, 2026, a follow up dental AVS indicated if sores/soreness developed from the new dentures R1 should take breaks (2 hours in, 2 hours out) with saltwater rinses to soothe his gums as needed. The AVS indicated staff should assist R1 with inserting and removing dentures daily because R1 was unable to do independently. The same day a dental progress note indicated unlicensed personnel (ULP)- N who accompanied R1 during the appointment reported staff had difficulty inserting and removing R1's partial denture. The note indicated adjustments to the partial were made, and ULP-N took a video for the licensee to provide instructions to staff on how to assist R1 to insert and remove the partial denture. However, a review of R1's assessment and service plan of care did not identify the instructions to unlicensed caregivers was updated to reflect this information regarding instructions for assistance, care, and monitoring of the new dentures as directed in the dental AVS. A review of R1's facility medical record including assessment and service plan of care did not identify instructions to unlicensed personal to assist R1 with his new denture/partial denture	0 450			

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0 450	Continued From page 4 including inserting and removing the dentures, brushing his teeth and gums after meals, monitoring for soreness, or providing saltwater rinses if soreness developed as directed in R1's dental AVSs. Additionally, the review of R1's record did not identify documentation of any oral/denture services provided. R1's assessment and service plan indicated R1 required full assistance with morning and bedtime grooming/personal hygiene including shaving, oral care, and other personal hygiene tasks. However, it did not include interventions specific to R1's denture and oral care needs. R1's record included nonspecific documentation that assistance with grooming/personal hygiene was documented as provided on rare occasions not morning and bedtime as indicated in the assessment and service plan of care. The same documentation indicating staff provided grooming/personal hygiene assistance did not indicate whether denture or oral care was provided as directed. On May 6, 2026, another dental AVS and dental progress note indicated R1 was seen for a follow up appointment, R1 had heavy oral food debris noted. Upon removal of R1's lower partial denture a "suction" noise was heard and R1 expressed pain upon removal. The AVS and dental progress note indicated heavy bleeding occurred when the partial denture was removed and R1 had a large U-shaped sore on the floor of his mouth with epulis present on gingival tissues were red and bulbous (bulging swollen) indicating R1's partial denture had been in his mouth for a pro-longed period of time. The AVS and dental progress note indicated R1 was dependent on the licensee staff for care and unable to insert and remove the dentures on his own. The AVS and dental progress note included orders for R1 not to wear	0 450			

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0 450	Continued From page 5 his dentures and provide warm saltwater rinses twice per day for the next 7 days for wound care. A review of R1's dental/oral pictures provided from May 6, 2026, visit showed swelling, redness, and bleeding in the shape of the partial denture spanning the base of R1's mouth as documented in the AVS and dental providers progress note. R1's assessment and service plan of care updated May 6, 2026, (after R1 developed epulis, sores, bleeding, and pain) indicated R1 had new dentures and required full staff assistance with management in the morning and at bedtime. The assessment and service plan of care lacked specific instructions as indicated on the AVS. The assessment and service plan of care lacked specific directions as indicated on the dental AVS's for staff to implement. R1's medication and treatment administration record (MAR/TAR), included orders for saltwater rinses and oral care twice daily initiated on May 6, 2026, following the incident which were documented as provided. On June 17, 2026, a dental progress note indicated R1 was seen for a follow up and the epulis sore spots had healed. The note indicated R1 could only wear dentures if there was 100% certainty that licensee staff would provide assistance to remove and insert them daily. The note indicated R1 should not wear the dentures because he was dependent on staff, and it was uncertain he would receive assistance with his dentures On July 13, 2026, at approximately 1:00 p.m. during an entrance conference with licensee leadership including Executive Director-Licensed Assisted Living Director (ED-LALD)-G, Registered Nurse-Director of Nurses	0 450			

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0 450	Continued From page 6 (RN-DON)-H, and Licensed Practical Nurse Supervisor (LPN)-G denied being aware staff had not provided dental care or services including assistance with inserting, removing, or oral hygiene. Leadership indicated they monitored to ensure care and services were provided and they had no concerns R1 had not received denture and oral care assistance. Leadership denied being aware of any concerns or receiving specific orders/instructions regarding R1's denture/partial denture care until after bleeding, sores, and epulis developed. On July 13, 2026, at 2:12 p.m. ULP-D stated she brushed R1's teeth but thought R1 had his own teeth and did not ever recall receiving instructions to insert or remove R1's dentures. On July 13, 2026, at 2:24 p.m. ULP-F stated she did not know R1 had dentures or needed assistance with inserting or removing them. On July 17, 2026, at 11:35 a.m. ULP-M indicated she had brushed all R1's teeth as a standard of care in the morning and at bedtime, but did not recall R1 had dentures/partial dentures or needed assistance to insert or remove them. On July 17, 2026, at 11:50 a.m. ULP-L stated she provided R1 with assistance brushing his teeth but was not aware R1 had a partial denture, dentures, or missing teeth. On July 17, 2026, at 12:07 p.m. ULP-N stated she had accompanied R1 to two follow up dental appointments after he reviewed his new dentures. ULP-N stated the licensee was aware R1 required assistance with oral/denture care including inserting and removing the partial denture because she had given the dental AVS's	0 450			

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0 450	Continued From page 7 and video instructions on how to insert and remove R1's partial denture to the licensee. ULP-N stated she was horrified when R1 developed sores and bleeding from staff not removing the partial denture. On July 17, 2026, at 12:30 p.m. Licensed Practical Nurse (LPN)-K indicated she was not aware R1 had new dentures, or issues with staff inserting or taking the dentures out. On July 17, 2026, at 5:05 p.m. Executive Director (ED)-J indicated the documentation of care and services provided was only as needed documentation (PRN) documentation and was not an indication of services provided according to R1's service plan. ED-J indicated the licensee was unable to provide documentation to show denture/oral care and services were implemented or provided by staff at the time the incident occurred due to the licensee "POC Sage" documenting and reporting system limitations. ED-J indicated tasks were delegated to staff on a care task sheet that provided specific information on specific resident cares located in the nurse's office. ED-J indicated the licensee had no monitoring efforts in place to ensure cares and specifically oral hygiene were being completed for R1 at the time of the incident. The care task sheets with R1's specific care instructions from the time of the incident were requested, however none were provided. On July 21, 2026, at 11:31 a.m. R1's Doctor of Dental Science (DDS)-B stated some challenges and soreness with new dentures were expected, and instructions for care and monitoring were provided to the licensee which she expected them to implement. DDS-B indicated R1 was dependent on staff assistance with denture and	0 450			

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0 450	Continued From page 8 oral care and indicated staff had taken a video of the partial insertion and removal process to ensure staff understood how to insert and remove the dentures. When R1 was seen on March 24, 2026, R1 had no sores, and an AVS provided to the licensee again directed staff to assist R1 with inserting, removing the dentures, and monitoring for soreness. DDS-B stated she received no communication of any concerns from the licensee. Then, about two months later DDS-B stated R1 had developed epulis a tissue overgrowth caused by continuous wearing of dentures over a prolong period of time (usually months). DDS-B stated the epulis overgrowth was not normal and was an indication that R1's partial denture likely never left his mouth. DDS-B stated when the partial was removed a loud suction noise was heard which was also not normal and R1 had heavy bleeding, large sores, and severe pain. DDS-B stated in her professional opinion what she observed (epulis, sores, bleeding, and pain) was from having the partial in his mouth for far too long and "prolong neglect of care". DDS-B indicated due to the uncertainty licensee staff would consistently ensure denture and oral care was provided as ordered, it was safer for R1 to not wear his dentures due to the risk of recurring epulis, sores, bleeding which would put R1 at risk for complications like infection or additional tooth loss. A licensee policy and procedure titled "Denture Care" dated February 28, 2024, indicated staff would provide safe hygienic and thorough denture care assistance including checking for mouth sores and redness, notifying nursing of any oral issues, assisting with removing/placing dentures and storing them, and documenting denture care and services provided.	0 450			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21387	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/13/2026
NAME OF PROVIDER OR SUPPLIER ROSE ARBOR/WILDFLOWER LODGE			STREET ADDRESS, CITY, STATE, ZIP CODE 16500 92ND AVENUE NORTH MAPLE GROVE, MN 55311		
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0 450	Continued From page 9 A licensee policy and procedure titled, "Service Plan", dated February 28, 2024, indicated all residents receiving assisted living services will have a service plan in place. The same document indicated service plans are based on the outcomes of initial and subsequent assessments, reassessments, monitoring, and individual reviews of the resident's needs and preferences. A service plan means the written plan between a resident or resident's designated representative and the licensee about the services that will be provided to the resident. Other provisions of this policy included Section 3 which indicated services plans shall be revised, if needed, based on resident reassessments and monitoring. Section 9 indicated a service plan will include a description of the service to be provided based on the most recent assessment and resident preferences, frequency of each service, identification of staff providing the service, and a schedule method for monitoring staff providing the service with a contingency plan that includes actions to be taken if the service cannot be provided. Other optional documents such as care plans or assignment sheets are internal documents that may be used to assist staff with understanding their daily assignment and tasks, but they were not required and do not replace the required service plans. A licensee policy and procedure titled, "Resident Record Documentation" dated February 28, 2024, indicated staff would document in the resident record all medications, services, treatments, and therapies provided for each resident. Section 4. indicated when a task was not performed or administered staff must document the reason it was not preformed. Section 5. indicated tasks not performed must be followed up on to ensure	0 450			

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER ROSE ARBOR/WILDFLOWER LODGE			STREET ADDRESS, CITY, STATE, ZIP CODE 16500 92ND AVENUE NORTH MAPLE GROVE, MN 55311		
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0 450	Continued From page 10 the needs of the resident were met. Section 6. indicated in addition to scheduled tasks other pertinent information that should be documented in the resident record included but were not limited to information about new problems, resident family concerns, any changes in the resident condition, incidents, and family problems. A licensee policy and procedure titled "Supervision of Staff", dated February 28, 2024, indicated staff who provide delegated nursing or therapy tasks to residents will be supervised by an RN or appropriate licensed health professional where the services are being provided to verify that work is being performed competently and to identify problems and solutions related to the staff person's ability perform the tasks. Supervision will include observation of the staff administering the medication or treatment and the interaction with resident. It is the responsibility of the RN staff to ensure the supervision is done within the times outlined above and specified on the service plan. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 450			
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: Based on interviews and document review, the licensee failed to ensure one of one residents (R1) reviewed was free from maltreatment.	02360			

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02360	Continued From page 11 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			