Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL333763481M
Compliance #: HL333763754C

Date Concluded: August 27, 2024

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

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Christine Bluhm, 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:
The facility neglected the resident when they did not provide supervision to the resident and the resident obtained a lighter, intentionally set fire in her bedroom and attempted to harm herself. The resident had a history of setting a fire where she lived previously.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. While the facility had hired additional staff members to provide supervision for the resident, the facility did not ensure this supervision was provided. The facility had assessed the resident for high-risk behaviors and developed interventions, which included all lighters were to be locked up. The resident expressed anxiety and a desire to leave the facility, but the facility did not provide supervision, which allowed her to obtain a lighter and start a fire in her bedroom.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the city fire and police department for call records and investigation reports. The investigation included review of the resident record, hospital records, facility incident reports, staff schedules, related facility policy and procedures. The investigator reviewed multiple facility camera recordings that were recorded that morning of the fire.

The resident resided in an assisted living facility similar to a small group home setting. The resident's diagnoses included multiple mental health disorders. The resident's service plan included assistance with appointments, shopping, transportation, finances, housekeeping, meals, and medication administration. Her services also included managing behaviors of agitation and anxiety and interventions to prevent property destruction and self-injury. The resident's assessment indicated she had a history of setting fire to her bedding and pillows at a previous facility.

The day of the incident, facility staff did not follow the interventions in place when the lighter was not locked up or engage in supervision of the resident when the resident verbalized, she did not want to be at the house and wanted to go to the hospital. The resident obtained a lighter and started a fire in her bedroom.

Review of an emergency room visit note indicated that on a prior occasion, staff brought the resident in to be seen after she reported having suicidal thoughts with a plan to light pillows on fire. The doctor's note indicated the resident had engaged in self-harm previously when she lit pillows on fire at the previous group home. The note indicated staff did not allow her to keep lighters, and the manager planned to add one additional staff member to allow for increased supervision of the resident. Based on these precautions, the doctor agreed the resident was safe to return to the group home.

The resident's facility progress notes indicated there were times where the resident reported feeling anxious or agitated that required staff intervention. One time, staff contacted the crisis line, and the resident was taken to the hospital and remained in the hospital for a couple of weeks.

The facility incident report for this occasion indicated there was a fire one morning in the home. The fire, which was set by the resident, indicated the incident had been preventable as staff members were responsible for obtaining the lighter from the resident, monitoring the resident with safety checks and documenting self-injurious behavior.

The progress note addressing this incident indicated the resident admitted to setting the fire because she was bored, did not want to be there, was attempting suicide and she was being bullied by another resident.

Video footage, which included audio, from inside the home the day of the fire showed the

resident came upstairs and greeted staff member #1 and picked up the lighter as she walked by the cabinet where it was kept. The resident went out to smoke on the patio with another resident sharing one cigarette between them. The video showed both residents come back inside, and the resident gave the lighter to staff member #1, who then placed the lighter back in the cabinet. Shortly after that, the resident became upset in the kitchen area, stated she did not want breakfast, did not want to be at the facility anymore, and asked to be taken to the hospital. Staff member #1 suggested she give it some time and reminded her that she feels this way after she smokes. The resident left the kitchen area, walked to the stairway, looked back at the staff member who was not looking, and reached into the cabinet where the lighter had been placed and went downstairs. Meanwhile, the footage showed staff member #2 on the couch who did not acknowledge nor engage with the resident. A short time later, smoke is shown coming from downstairs while the resident can be heard calling for help. The two staff members evacuated the other residents out of the house, but the resident was left in the downstairs.

During an interview, a manager stated staff were trained how to respond when the resident had behaviors and lighters were to be locked up. The manager stated she did not review the incident video from the day of the fire.

During interview, the director stated a second staff member was added for additional supervision of the resident. The director stated he did not review the incident video from the day of the fire.

During interview, staff member #2 stated the resident had an anxiety episode and did not feel comfortable, so she went downstairs to “reset” which was not unusual. Staff member #2 stated she got up and walked to the top of the staircase to check on the resident and black smoke was coming up the stairway which does not corroborate with the video.

A review of the video did not identify that staff member #2 walked to the top of the stairway. Rather staff member #2 stayed seated on the couch in the living area, not interacting with the resident at all when she became upset. Staff member #2 only moved from the couch when another resident yelled there was smoke. The video showed neither staff member were seen going to the stairway or attempting to direct the resident out of the home.

Fire department reports indicated all evidence at the scene showed the resident started the fire in her lower-level bedroom which had no smoke detector.

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, attempted but could 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:
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
Dakota County Attorney
Burnsville City Attorney
Burnsville Police Department
Burnsville Fire Department

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 05/15/2024

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 ******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: #HL333763754C/#HL333763481M On May 15, 2024, 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 four residents receiving services under the provider's Assisted Living license. The following correction order is issued, 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.	
02360	144G.91 Subd. 8 Freedom from maltreatment	02360		

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02360	Continued From page 1 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		