Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL333765444M
Compliance #: HL333769357C

Date Concluded: April 13, 2023

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

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Peggy Boeck, RN
Special Investigator

Finding: Not Substantiated

Nature of Visit:
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 a resident when they failed to implement interventions to keep the resident safe from others as well as keep the resident safe from self-harming.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The facility assessed the resident for areas of vulnerability and put interventions into place to keep the resident safe. Although the resident reported physical and sexual abuse from a peer, there was no corroborating evidence. The facility was aware the resident was in a relationship with a peer. The facility staff discussed the relationship with the resident's respective care teams, as well as set boundaries within the facility to address physical affection between the resident and peer. When the resident initiated a suicide attempt, a staff quickly intervened and prevented the resident from harming herself.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement. The investigation included review of incident reports, law enforcement reports, medical records, policies, and procedures related to assessments, peer relationships, supervision of residents, abuse prevention plans, staffing, and maltreatment of vulnerable adults. Also, the investigator observed staff/resident interactions.

The resident lived in an assisted living facility due to mental health diagnoses. The resident's service plan included assistance with behaviors that included agitation, anxiety, reality disorientation, physical aggression, and self-injury. The resident's assessment indicated staff interventions included use of short simple explanations, allowing the resident time to calm, active listening, verbal redirection, listening versus arguing, use of a calm but firm approach, creating physical distance, and offering options and choices to give the resident a sense of control.

About a week after the resident moved into the facility, she notified an administrative staff that she had interest in another resident. The administrative staff, the resident, and the peer discussed their rights to interact with whoever they wanted and reinforced respectful behavior regarding others living in the facility. The resident and peer occasionally left the facility together to spend time alone. The resident and the peer had arguments and would make up.

The peer moved out several months later, and the relationship was over. The resident reported a week after he left, the peer was physically and sexually aggressive with the resident. The resident expressed fear of the peer calling her or trying to visit the facility and reported to a staff she had seen him in another female resident's room.

During an interview, an administrative staff stated the resident was stressed out when the peer moved out, because he tried to convince her to go with him. The administrative staff stated the resident left with the peer on the day he moved out but returned within a couple of hours. The administrative staff stated the resident experienced unusual beliefs that she saw him in the facility, he was hacking her e-mail, and the resident's mental health declined. The administrative staff stated the facility had not seen or heard of any signs of physical abuse or sexual activity between the resident and peer.

During an interview, a staff member stated one day the resident was having a bad day, so she watched her more closely. The staff stated the facility trained the staff about mental health and how to approach a resident depending on what symptoms they were experiencing. The staff stated the resident went downstairs into her room and the staff followed her. The staff stated the resident grabbed a computer cord and wrapped it around her neck tightly, so the staff removed it and called 911. The staff stated the resident stayed in the hospital for a few days and returned.

During an interview, the resident's case worker stated she had concerns about the resident and peer comingling their finances but had no evidence of financial exploitation. The case worker stated the resident experienced an increase of delusions after the relationship concluded. The case manager stated the facility provided the resident with good support, kept the case manager up to date, and the resident was now doing well.

In conclusion, 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: Yes
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
The facility nurse reassessed the resident needs and implemented additional staff interventions.

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
	33376	A. BUILDING: _____ B. WING _____	C 04/03/2023

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 On April 3, 2023, the Minnesota Department of Health initiated an investigation of complaint #HL333769357C/#HL333765444M. No correction orders are issued.	0 000		