Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL339753665M
Compliance #: HL339757051C

Date Concluded: July 22, 2025

Name, Address, and County of Licensee Investigated:
Maple Woods Assisted Living
33310 State Highway 6
Deer River, MN 56636
Itasca County

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

Evaluator's Name:
Katherine Barnhardt 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), facility unlicensed personnel, abused the resident when the AP held her hand over the resident's mouth until the resident swallowed the liquid in his mouth.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was substantiated. The AP was responsible for the maltreatment. During a verbal altercation between the AP and resident, when the AP thought the resident was about to spit water on the AP, the AP physically held her hand over the resident's mouth until the resident swallowed the water. The resident was at risk for choking.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement and a resident representative. The investigation included review of the resident record, pharmacy records, facility internal investigation, facility incident reports, personnel files, staff schedules, law

enforcement report, and related facility policy and procedures. Also, the investigator observed unlicensed personnel provide direct cares.

The resident resided in an assisted living facility. The resident's diagnoses included traumatic brain injury and a seizure disorder. The resident's service plan included assistance with behavior management and medications. The resident's assessment indicated the resident received nourishment and medications through G-tube feedings (surgically placed device allowed direct access to stomach for feeding, hydration or medicine) however, was able to eat and drink small amounts while up in his wheelchair with assistance. The resident was alert, oriented and relied on staff for repositioning, wheelchair mobility, transfers using a mechanical sling lift, incontinence cares, and medication administration. The resident used a tilt-in-space wheelchair and was capable of adjusting the angle of the chair. The assessment indicated the resident was at risk for abuse and at times was verbally and physically aggressive toward staff, however, was redirectable.

The resident's record indicated the resident had a history of verbal and physical abuse toward staff with interventions in place. The resident's record indicated unlicensed personnel administered medications to the resident four times daily through the resident's G-tube and the resident verbalized his preferences through the process. At times, the resident refused medications, and staff were directed to reapproach the resident at a later time. If the resident continued to refuse the medications, staff were to document and report the refusal to the licensed nurse.

A facility internal investigation indicated during a routine resident record audit of service notes, management found a note written by the AP, fourteen days earlier, of a not reported altercation between the resident and the AP. The note indicated one afternoon, when entering the resident's room with the intent to provide medication administration through the G-tube, the resident met the AP at the door with verbal resistance asking the AP to leave the room several times. Instead, the AP continued with the medication administration and the resident became more upset. The resident grabbed the syringe from the AP's hand causing some of the liquid to leak out of the syringe. The AP continued to stay with the resident even though he continued to tell her to leave the room. The resident had water in his mouth and when the resident attempted to spit at the AP, the AP physically covered the resident's mouth with her hand until the AP swallowed the water. The facility reported the altercation to law enforcement.

When interviewed by management, the AP admitted to covering the resident's mouth until the resident swallowed the water but stated she attempted to deescalate the situation stating it was not intentional.

When interview by management, the resident reported not feeling safe with the AP.

A law enforcement report indicated the AP was administering medications through the resident's G-tube when the resident grabbed the G-tube to stop the medication administration and would not allow his activated call pendant to be reset. The law enforcement report indicated the resident accused the AP of stealing items from him and the AP tried calming the resident down without success. The law enforcement report indicated the resident started yelling for management and requested twice that the AP leave his room. The law enforcement report indicated the resident put water in his mouth and gestured to spit on the AP and the AP covered the resident's mouth with her hand for an unknown amount of time.

During an interview, unlicensed personnel stated the resident was unpredictable and was physically and verbally aggressive to staff. Unlicensed personnel stated at times the resident was redirectable and other times the resident would be fixated on a topic, and it would go on for days. Unlicensed personnel stated the resident would single out certain staff and could be "really mean". Unlicensed personnel stated interventions for the resident's behaviors were in place and she provided cares with a second staff present due to the resident's behaviors.

During an interview, licensed staff stated management came across a service note written by the AP when conducting resident record audits. Licensed staff stated an internal investigation was initiated including interviews with all staff, the AP, and the resident. Licensed staff stated the resident had a lot of behaviors but was redirectable and the resident's plan of care included interventions for staff when the resident was difficult. Licensed staff stated unlicensed personnel would stop mid-task if the resident requested and from the information provided the AP had not stopped and "things escalated". Licensed staff stated the resident attempted to rip the G-tube away from the AP to stop a medication administration and when the AP did not stop, the resident made a motion to spit at the AP. The AP put her hand over the resident's mouth until the resident swallowed. Licensed staff stated the AP should have walked away.

During an interview, the AP stated she had reviewed the resident's plan of care and was aware of the resident's behaviors. The AP stated the resident did not want her in his room and she did not want to be in his room. The AP stated the resident asked her to stop a G-tube medication administration halfway through and when she did not stop the resident knocked the G-tube out of her hand. The AP stated the resident requested she leave his room, but she stayed and attempted to administer the remaining medication and that escalated the resident's anger. The AP stated the resident was difficult for her to care for and she often requested another staff provide his cares because the resident was "rude" to the AP. The AP stated she "assumed" the resident was at risk for choking risk due to a brain injury and had put her hand over the resident's mouth "for less than 5 seconds" until the resident swallowed the water in his mouth. The AP initially stated she was not provided direction to assist with the resident's behaviors, however, stated an alternative to escalating the resident "in hindsight" would have been to walk away or have another staff assist with cares.

During an interview, a resident representative stated she was notified of the incident. The representative stated the resident could be difficult but unlicensed staff could walk away and return in five minutes and try again.

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;
(2) the use of drugs to injure or facilitate crime as defined in section 609.235;
(3) the solicitation, inducement, and promotion of prostitution as defined in section 609.322; and
(4) criminal sexual conduct in the first through fifth degrees as defined in sections 609.342 to 609.3451.
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;
(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening; or
(3) use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion, including the forced separation of the vulnerable adult from other persons against the will of the vulnerable adult or the legal representative of the vulnerable adult unless authorized under applicable licensing requirements or Minnesota Rules, chapter 9544.
(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.
(d) The act of forcing, compelling, coercing, or enticing a vulnerable adult against the vulnerable adult's will to perform services for the advantage of another.

Vulnerable Adult interviewed: No
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The facility licensed staff conducted an internal investigation, and the alleged perpetrator was terminated.

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
Itasca County Attorney
Deer River City Attorney
Deer River Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33975	A. BUILDING: _____ B. WING _____	C 07/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE WOODS ASSISTED LIVING	33310 STATE HIGHWAY 6 DEER RIVER, MN 56636

(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: #HL339753665M/ #HL339757051C #HL339753702M /#HL339757148C On July 8, 2025, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction order is issued. At the time of the complaint investigation, there were 21 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL339753665M/ #HL339757051C, 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.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02360	Continued From page 1	02360		
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 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		