Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL374779422M
Compliance #: HL374778462C

Date Concluded: May 23, 2025

Name, Address, and County of Licensee Investigated:
Midwest Residential Care - Maple House
140 Maple Island Road
Burnsville, MN
Dakota County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Christine Bluhm, RN
Special Investigator

Finding: Not Substantiated

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 alleged perpetrator (AP), an unknown caregiver, abused the resident when they were rough during personal care and transfer assistance resulting in bone fractures and bruises. It was also alleged the facility did not seek medical care for the resident's pain.

Investigative Findings and Conclusion: The Minnesota Department of Health determined abuse was not substantiated. The facility transferred the resident to the hospital for back pain where left leg fractures were identified but attributed to be likely non-trauma related. The resident sustained an additional injury while using her electric wheelchair. It was found that nursing staff routinely facilitated medical appointments and emergency care for the resident for various ailments including sources of pain. While the resident did express concerns about a caregiver, the identity of the AP could not be confirmed, nor a specific event identified.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted the case worker. The investigation included review of the resident records, hospital records, staff schedules, and related facility procedures. During a recent visit to the facility, the investigator observed caregiver staff and resident interactions.

The resident resided in an assisted living facility with a diagnosis of stroke with left-sided paralysis. The resident's service plan included assistance with activities of daily living including all bed repositioning, mobility and transfers to and from the wheelchair by use of a total-assistance (Hoyer) mechanical lift. The resident's assessment indicated she was able to make decisions and could verbalize her needs to facility caregivers and medical providers. The resident used an electric wheelchair for mobility.

One day several concerns arose regarding injuries the resident sustained while at the facility. The resident stated she had been injured including broken bones and that a caregiver had been "rough" with her. The resident could provide a partial name for the caregiver.

Three months prior to this concern arising regarding the caregiver the progress notes indicated sent the resident to the hospital due to ongoing pain.

The resident's hospital summary indicated the resident was seen for back pain radiating down the left leg. Medical imaging revealed the resident had a compression fracture of the lower spine and a fracture in the tibia and fibula bones in her left leg as well as an old fracture deformity in the left femur (upper leg bone). The note indicated the resident could not recall a specific event or cause of the recent injury, but it appeared to be non-trauma related. There was also evidence diffuse bone loss and prior surgery in the left leg related to past fractures. The resident received care in the hospital and returned to the facility.

During an interview, a member of the nursing team stated it was documented in her medical chart that she had similar fractures some years ago. The nurse stated the resident's hospitalization was prompted by increased back pain and it was there that newer fractures were found. The facility was unaware of any specific events to which to attribute the injuries.

About two and half months later, progress notes indicated later the resident injured her left foot and required stitches to her toes after the resident accidently ran her foot into a wall while maneuvering her electric wheelchair within her room.

During interview, the resident stated she currently did not have current complaints of caregivers but had experienced male and female staff being rough in the past. She stated she has pain related to the mechanical lift sling itself used during the transfers.

During observation, the investigator watched repositioning and mechanical lift transfer from the bed to her wheelchair. The resident verbalized pain incidental to the transfer, however no poor technique on the part of caregivers was observed.

During interviews, multiple staff members stated the resident complained of pain with movement and repositioning.

During interview and since the onsite facility visit, a manager stated the resident just recently had a ceiling mounted mechanical lift placed that has made an improvement in the transfer process and has benefited the resident. The manager also stated a caregiver who may have been the person the resident referred to as providing “rough” cares was no longer employed at the facility and no specific concerns were brought to the facility’s attention any concerns prior to this investigation. The resident was encouraged to bring forth any concerns right away.

In conclusion, the Minnesota Department of Health determined abuse 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.

Abuse: Minnesota Statutes section 626.5572, subdivision 2.
"Abuse" means:
(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.

Vulnerable Adult interviewed: Yes.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: No AP identified during the investigation.

Action taken by facility: No action taken.

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
	37477	A. BUILDING: _____ B. WING _____	C 05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDWEST RESIDENTIAL INC	140 MAPLE ISLAND ROAD BURNSVILLE, MN 55306

(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 May 7, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL374778462C/#HL374779422M. No correction orders are issued.	0 000		