Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL402233638M
Compliance #: HL402233382C

Date Concluded: October 12, 2026

Name, Address, and County of Licensee Investigated:
Caretta Senior Living
1910 County Rd C East
Maplewood, MN 55109
Ramsey County

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

Evaluator's Name: Brandon Martfeld, RN, BSN, Special Investigator

Finding: Inconclusive

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 perpetrators (AP #1 and AP #2) abused the resident when both AP #1 and AP #2 used physical force to administer medications which caused injuries to the resident.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was inconclusive. AP #1 and AP #2 went to administer a powder medication to the resident and the resident refused. During the investigation there was conflicting documentation and interviews as to who may have caused the skin tear, how the resident received a skin tear, and that the resident may have had a previous skin tear to his arm.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident records, facility internal investigation, personnel files, staff schedules, and related facility policy and

procedures. Also, the investigator observed staff attempt to administer medication to the resident.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia, depression, and long-term use of anticoagulants (medications that decrease your blood's ability to clot). The resident's service plan included assistance with medication administration and behavior management. The service plan indicated the resident had a history of becoming aggressive and agitated with staff and that staff were directed to pause, step away, and approach again later with a calm and slow demeanor. The resident's assessment indicated the resident had mild cognitive impairment and that the resident had dry, fragile skin and diffused bruising on his arms. The resident's assessment indicated the resident had an open healing area with a scab on the left upper arm. The resident's assessment indicated staff were trained on signs of abuse and were to notify the nurse of any known concerns or potential concerns for abuse.

The resident's medical record indicated the resident reported to a nurse that two staff members attempted to apply powder to his groin area and recalled telling both staff members no, he did not want the powder. The staff continued to attempt to administer the powder. The resident recalled becoming aggressive and put hands on one of the staff members. Both staff members used force to remove the resident's arm and caused a skin tear on his left forearm. The medical record indicated the resident initially applied band aides to the skin tear. The nurse cleansed the skin tear and applied a dressing.

The facility's internal investigation indicated AP #1 and AP #2 attempted to apply powder to the resident's groin area. The resident refused the powder, and both AP #1 and AP #2 grabbed his left arm, but that AP #2 caused a skin tear to his arm. The facility investigation indicated AP #1 and AP #2 were in the resident's room; the resident grabbed onto AP #2, and she pulled or flung her arm in way that caused the resident's arm to hit a grab bar or doorframe which caused a skin tear. The internal investigation indicated AP #2 stated the resident pulled her jacket/sweatshirt around her neck which resulted in marks around her neck. AP #2 stated the incident was not "that big of a deal" and was not a "significant issue." The resident sustained a 1.8-centimeter by 1.9-centimeter skin tear and bruise on his left forearm.

During a facility interview AP #1 stated the resident grabbed AP #2 by her jacket and tried to choke her while she was attempting to put powder on the resident. AP #2 grabbed the resident's arm and caused a gash on his arm by tossing his left arm against the garb bar. AP #1 stated in the interview, she did not do anything during the incident.

During a facility interview AP #2 stated the resident grabbed both AP #1 and AP #2. AP #1 stated the resident grabbed her by her sweatshirt, and the resident hit his arm on the door. However, AP #2 also stated she could not remember or did not know how the resident got the skin tear on his arm.

Text messages between AP #1 and AP #2, indicated AP #1 told AP #2 that she did not cause the skin tear to the resident's arm. The text message indicated the resident already had a skin tear to his arm prior to the incident between the resident, AP #1 and AP #2.

During an interview, AP #1 stated she was working with AP #2 one morning and the resident had a powder that needed to be applied because he had a rash in his groin area. AP #1 stated she asked AP #2 to apply the powder to the resident because the resident was often mean towards her. AP #1 and AP #2 entered the resident's bathroom, the resident stated he did not want the powder, AP #2 went to apply the powder and the resident grabbed onto AP #2's jacket. The resident stated you are not going to do anything for me. AP #1 stated she was just standing there watching, and AP #2 yanked (to pull or move something quickly and with a sharp, forceful motion) the resident's arm, which caused the resident to hit his arm on a rail. The resident's arm began to bleed. AP #1 stated they left the resident in the bathroom, and that AP #2 was mad. Following the incident she asked AP #2 if she was going to do anything with resident's arm, fill out an incident report, or call the on-call nurse and AP #2 stated she would take care of it. Then the next day, AP #2 was asked if she reported the incident with the resident and AP #2 stated she was not going to report the incident. AP #1 stated the incident should have been reported immediately. AP #1 stated when a resident refused medications, they were to try three times and if the resident continued to refuse, then a note in the electronic medication administration record would be made to indicate the resident refused the medication. AP #1 stated the resident had a right to refuse the medication and that a resident should not be forced to take their medications.

During an interview, facility leadership stated a call was received because of a verbal altercation between AP #1 and AP #2. During an investigation, it was determined the verbal altercation was from an incident that involved the resident. It was determined that AP #1 and AP #2 attempted to apply powder to the resident. The resident refused the powder and it was reported that AP #2 grabbed the resident's left arm and tossed it against a grab bar in the bathroom. This resulted in the resident sustaining a skin tear. Facility leadership stated the expectation for when a resident refused a medication was that staff backed away, re-approached at a different time and if the resident continued to refuse the medication, then staff would notify a nurse. Facility leadership stated they would not expect staff to force a resident to take a medication if the resident refused a medication.

During an interview, the resident stated he could not remember the staff members' names and could not recall the events of the incident completely but remembered being in the bathroom when his right arm was twisted which caused a bruise. The resident stated AP #2 came back after the incident and apologized to him. The resident stated after the incident he was fine.

AP #2 declined to be interviewed.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.

"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or did not occur.

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: Yes.
Family/Responsible Party interviewed: No, per the request of the resident.
Alleged Perpetrator interviewed: Yes, for AP #1 and no, for AP #2.

Action taken by facility:
The resident’s primary care provider and family member was updated of the incident. Wound care was completed to the resident’s arm, AP #1 and AP#2 were suspended, and an internal investigation was completed. In addition, staff were educated on abuse and reporting abuse. AP #1 or AP #2 are no longer employed by the facility.

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
	40223	A. BUILDING: _____ B. WING _____	C 09/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARETTA SENIOR LIVING MAPLEWOOD LLC	1980 COUNTY ROAD C EAST MAPLEWOOD, MN 55109

(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 September 14, 2026, the Minnesota Department of Health initiated an investigation of complaint #HL402233638M / #HL402233382C. No correction orders are issued.	0 000		