Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H54933103M
Compliance #: H54936883C

Date Concluded: July 1, 2026

Name, Address, and County of Licensee Investigated:
Augustana Chapel View Care Center
615 Minnetonka Mills Road
Hopkins, MN 55343
Hennepin County

Facility Type: Nursing Home

Evaluator's Name: Willette Shafer, 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(s):
The alleged perpetrator (AP) emotionally abused the resident when the AP yelled at the resident to speak English and walked out of the resident's room several times when the resident spoke Russian.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was not substantiated. The AP was observed on surveillance video entering the resident's room. When the resident spoke Russian, the AP told the resident she did not understand Russian and told the resident to speak English. The AP left the resident's room when she continued to speak Russian. The AP asked another staff member to assist the resident as she was unable to understand the resident. Another caregiver assisted the resident with her cares. The resident was assessed, and no physical or emotional trauma resulted from the interaction.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family member. The investigation included review of the resident records, facility internal investigation, personnel files, staff schedules, and video surveillance.

The resident resided in a nursing home. The resident's diagnoses included stroke, anxiety, depression, and muscle weakness. The resident's service plan included assistance with medication management, grooming, dressing, transferring, incontinence care, and housekeeping. The resident's assessment indicated the resident had a language barrier. The assessment indicated numerous interventions to assist with communication before the incident and new interventions were implemented after the incident.

A surveillance video of the resident's room showed the AP enter and tell the resident to "speak English, I only know English." The AP asked the resident "What do you need?" The resident continued to speak in another language. The AP left the room. The AP entered the resident's room a second time and removed dirty linen from the floor. The AP took the pendant light out of the resident's hand and the resident grabbed it back. The resident attempted to hit the AP with the pendant light. The AP removed the pendant light again and tossed it on the floor. The resident spoke in a different language, and the AP told the resident she could not understand her and again told the resident to speak English. The AP removed the dirty linen from the resident's room. The third time the AP entered the resident's room the AP brought in clean linen and directed the resident to sit in her wheelchair. The resident said something to the AP in another language and the AP assisted the resident to move her legs to the side of the bed in a quick motion. The resident yelled out and the AP stopped. The resident repeated something to the AP several times and the AP said, "what is the issue" and left the room.

The internal investigation indicated multiple residents were interviewed, and denied having concerns with the AP. They all reported they felt safe at the facility.

The resident's skin assessment completed after the incident indicated no injuries to the resident's skin.

A mental health assessment completed by a psychologist after the incident indicated the resident was not emotionally or mentally disturbed by the incident. She reported she was happy and felt safe at the facility and received good help from staff. The resident described her mood as "fine and perfect."

The AP's training transcript indicated she completed all required training including vulnerable adult maltreatment, behavioral health and challenging behaviors, resident rights, cultural awareness, and dementia training multiple times while employed.

During an interview, the resident's family said the resident complained about a staff member in her room the night before. The family member watched the surveillance video and observed

the AP being rude and handling the resident in a rough manner. She said the AP yelled at the resident to speak English. The facility had interpreter services available for staff to utilize. Facility staff called her in the past to assist with communication. She said nobody called her during this incident. She reported the incident to the facility. The family member praised the facility for the way the incident was handled, and the resident was satisfied with the outcome. She said the incident was reported to the police, but no charges were filed.

During an interview, a member of management said she completed the internal investigation. She observed the surveillance video with the resident's family member. The video showed the AP take the call pendant away from the resident. The AP left the room and asked a nurse to assist the resident. A few minutes later the video showed the nurse enter the resident's room and assist the resident in a gentle and professional manner. She said the AP's behavior in the video was unprofessional and she no longer worked at the facility. The AP reported she was frustrated with the communication between her and the resident. A language interpreter phone number was posted in the resident's room. Staff were educated to call interpreter services for assistance. An internal investigation was conducted, and numerous residents and staff members were interviewed. None of the residents or staff members reported concerns with the AP's behavior towards them. She said the AP worked for the facility for 20 years and had a good work history. The AP had completed all required annual training before the incident.

During an interview, nurse-2 said she worked with the AP. Nurse-2 reported she never received any complaints from residents or staff members about the AP's behavior or resident care concerns.

The AP did not respond to interview requests.

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.

Vulnerable Adult interviewed: No, deceased.

Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: No. Did not return request for interview.

Action taken by facility:
The facility completed an internal investigation and completed re-education with staff members. The AP no longer worked at the facility.

Action taken by the Minnesota Department of Health:
MDH previously investigated the issue during a complaint survey under federal regulations, and substantiated facility 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.
You may also call 651-201-4200 to receive a copy via mail or email.

The purpose of this investigation was to determine any individual responsibility for alleged maltreatment under Minn. Stat. 626.557, the Maltreatment of Vulnerable Adults Act.

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 CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **06/18/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA CHAPEL VIEW CARE CENTER	**615 MINNETONKA MILLS ROAD , HOPKINS, Minnesota, 55343**

(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) COMPLETION DATE
20000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: The Minnesota Department of Health investigated an allegation of maltreatment, complaint #H54933103M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. No correction orders are issued. The facility is enrolled in the electronic Plan of Correction (ePoC) and therefore a signature is not required at the bottom of the first page of the State form. Although no plan of correction is required, it is required that you acknowledge receipt of the	20000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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20000	Continued from page 1 electronic documents.	20000		