Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL319683532M
Compliance #: HL319682939C

Date Concluded: July 27, 2026

Name, Address, and County of Licensee Investigated:
Maple Hill Senior Living
3030 Southlawn Drive
Maplewood, MN 55109
Ramsey County

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

Evaluator's Name:
Lacey Eggersdorfer, 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 perpetrators (AP #1 and AP #2), unlicensed staff, emotionally abused the resident when AP #1 and AP #2 took the resident's cell phone resulting in aggressive behavior.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined emotional abuse was not substantiated. AP #1 and AP #2 were not responsible for maltreatment. While AP #1 took the resident's phone away and AP #2 was aware of the phone being taken, it does not rise to the level of abuse. The resident also has history of agitation towards staff and other residents.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident records, pharmacy records, law enforcement reports, facility internal investigation, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. The investigator also observed staff interacting with the resident.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia, depression, and repeated falls. The resident's assessment indicated the resident was alert to person and place and had behaviors of frequently making non-emergent phone calls to 911. The resident's service plan indicated staff managed the behavior by providing the resident with reassurance of health and safety while the resident was allowed to keep her cell phone.

Progress notes indicated the resident had been aggressive towards staff previously. Six days prior to the incident the resident was in an altercation with another resident. The progress notes also indicated two days prior to the incident the resident had increased agitation.

An incident report indicated the resident was calling 911 for an unknown reason. AP #1 took the resident's phone away to prevent her from calling emergency services repeatedly. The resident became agitated and broke the facilities computer. The resident then walked away and fell on the floor but she did not get injuries from the fall. The incident report indicated the occurrence was captured on video footage.

Video footage of the incident was requested but was no longer available for review.

The internal investigation indicated the resident asked AP #1 for her phone back and became agitated when AP #1 said she did not have it. The resident attempted to hit AP #1. AP #2 then called the on call nurse to assist the resident in agitation.

In an interview, the nurse stated the resident was easily agitated and frequently called 911. The staff were expected to redirect the resident or administer an anxiety medication when a behavior occurred. She stated the resident had history of engaging in altercations with other residents.

In an interview, AP #1 stated the resident was pleasant but would have episodes of aggressiveness. She stated AP #2 was assigned the resident the night of the incident but had noticed the resident had called 911. She reassured the resident that she was safe and told 911 their services were not needed. She asked AP #2 to call the on call triage nurse about administering the resident's as needed anxiety medication. When the resident continued to call 911, AP #2 told AP #1 she could take the resident's phone away so she did. She stated she took the resident's phone because it was a common method all unlicensed staff used to calm the resident down. AP #1 stated she encouraged the resident to sit down and attempted to calm down the resident. The resident then walked away toward AP #2.

In an interview, AP #2 stated she was passing medication to other residents that night but called the on call nurse when she was made aware of the resident's agitation. She was aware that AP #1 had taken the resident's phone. AP #2 denied that AP #1 spoke to the resident in a way that was inappropriate or harsh. AP #2 attempted to help the resident after she broke the facility's computer and fell on the floor.

In an interview, the manager denied that AP #1 or AP #2 had any disciplinaries in the past related to emotional abuse. The manager stated the resident's 911 calls were escalating over the last year.

In an interview, a family member stated the resident has history of anxiety and being noncompliant with staff. He stated in his experience the staff have been kind and patient to the resident when she was noncompliant.

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, due to resident's dementia
Family/Responsible Party interviewed: Yes
Alleged Perpetrators interviewed: Yes

Action taken by facility:
The facility terminated AP #1 and AP #2.

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
	31968	A. BUILDING: _____ B. WING _____	C 07/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HILL SENIOR LIVING LLC	3030 SOUTHLAWN DRIVE 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 7/13/2026, the Minnesota Department of Health initiated an investigation of complaint #H319682939C/#H319683532M. No correction orders are issued.	0 000		