Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL319686642M
Compliance #: HL319689884C

Date Concluded: January 15, 2025

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: Brandon Martfeld, RN, BSN, 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), a facility staff member neglected the resident when the AP failed to provide care and supervision during an incident when the resident fell.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. At the time of the incident, the AP was following the resident's plan of care. The resident sustained a fall and was transported to the hospital.

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, death record, hospital records, facility internal investigation, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed staff interactions with residents.

The resident resided in an assisted living memory care unit. The resident's diagnoses included a history of falling, dementia, and Alzheimer's disease. The resident's service plan included assistance with day and evening safety checks. The resident's assessment indicated the resident was independent with transferring, walking and toileting. The resident had not had a fall for the past three months.

The facility investigation indicated one day the resident had a fall in the early morning hours. Another resident heard the resident yelling out for help. The other resident notified emergency services, met the emergency services at the front door of the facility, and escorted emergency services to the resident's room. Emergency services transported the resident to the hospital for an evaluation.

The emergency service report indicated the resident was found in her apartment. The resident reported her legs gave out and that she fell. The emergency service report indicated the resident was found with no signs of a hip fracture. The resident was transferred to the hospital for further evaluation.

The hospital record indicated the resident reported she fell and landed on her left hip. The resident sustained a left hip fracture, was hospitalized for nine days, and transferred to a higher level of care.

The resident records indicated the resident did not have scheduled activities of daily living services or safety checks at the time of the incident.

During an interview, leadership stated camera footage was reviewed and that the AP entered the nurse's station and remained in the nurse's station for approximately four hours. During the time the AP was in the nurse's station, the other resident was seen on the camera footage, meeting the emergency services at the front door, and escorting the emergency services down to the resident room and within minutes, the resident was assisted out of the facility by the emergency services. Facility staff can be seen on camera footage completing rounds approximately one hour after the resident was taken to the hospital. Leadership stated the other resident did not notify facility staff that emergency services was called, and that the resident left the facility until later that morning when the resident family member came to the facility looking for her. Leadership stated during the times the AP was in the nurse's station, the resident did not have any scheduled services to be completed.

During an interview, the AP did not recall working the morning of the incident.

During an interview, the family member stated facility staff assisted the resident with medications in the morning and evening. The family member stated the resident walked independently in the apartment. The family member stated the morning of the incident, they arrived at the facility when the other resident approached them and stated they had called

emergency services because the resident fell earlier that morning and was transported to the hospital.

In conclusion, the Minnesota Department of Health determined neglect 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.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
“Neglect” means neglect by a caregiver or self-neglect.
(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.

Vulnerable Adult interviewed: No. Resident was deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
Once the facility learned the resident was no longer at the facility, the facility began an investigation. The facility installed additional cameras. The AP is 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
	31968	A. BUILDING: _____ B. WING _____	C 12/30/2024

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 December 30, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL319686642M/#HL319689884C. No correction orders are issued.	0 000		