

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL319689242M
Compliance #: HL319683180C

Date Concluded: June 1, 2026

Name, Address, and County of Licensee

Investigated:

Maple Hill Senior Living
3030 Southlawn Dr.
Maplewood, MN 55109
Ramsey County

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

Evaluator's Name: Deb Schillinger RN BSN
Special Investigator

Finding: Substantiated, individual responsibility

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):

Allegation #1: Alleged perpetrator (AP) #1 abused the resident when she snapped “don’t do that” when the resident pulled her hair.

Allegation #2: AP #2 abused the resident when she shoed her away and spoke to the resident in a humiliating way.

Allegation #3: AP #3 abused the resident when she turned a chair around so the resident could not sit in a chair beside her.

Investigative Findings and Conclusion (s)

Allegation #1: The Minnesota Department of Health determined abuse was not substantiated. The AP’s hair was unexpectedly pulled from behind her. To say “don’t do that” would be an appropriate or expected response. No video of incident was provided.

Allegation #2: The Minnesota Department of Health determined abuse was substantiated. AP#2 became upset when the resident refused medications, then spoke to the resident in a demeaning and humiliating way.

Allegation #3: The Minnesota Department of Health determined abuse was inconclusive. AP #3 turned the chair around and told the resident to sit in a different area because she was sick and didn't want to get the resident sick. AP#3 stated she redirected the resident to the TV area and turned the TV on for the resident, however the video ended before showing the AP turning the television on.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident record, facility internal investigation, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed facility staff and resident interactions during an onsite visit.

The resident resided in a secured assisted living memory care unit. The resident's diagnoses included dementia and frequent falls. The resident's service plan included assistance with medication management and administration, cueing and reminders for meals and activities. The resident's assessment indicated memory impairment, was alert to person only and walked with a walker.

Allegation #1

A concern arose that AP #1 abused the resident when she was seen on video footage snapping at the resident for touching her hair.

AP #1, an unlicensed caregiver, was working in the memory care unit the day of the incident but was not assigned to care for the resident that day.

During an interview, the manager stated she viewed video footage at around 7:00 a.m. the resident was seen touching the AP's hair, she stated the AP then turned around and snapped "don't do that" at the resident.

During an interview, AP #1 stated the resident did pull her hair but stated she did not raise her voice to the resident. AP #1 stated she moved her hair away and asked the resident to please not touch her hair.

The video footage was requested but was not available.

A document provided by the facility indicated AP #1 sent an email to the manager resigning her employment.

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.

Allegation #2

A concern arose that AP #2 abused the resident when she was viewed in video footage speaking to the resident in a humiliating way.

AP #2, an unlicensed caregiver employed at the facility at the time of the incident and was assigned to provide care for the resident on the day of the incident.

Beginning at 7:29 am, video footage, which included audio, showed the AP assisting the resident with medication administration. The resident was recorded saying “Ow, goddamn it”, then AP #2 stated “Get on” shooing the resident away.

She then stated if the resident did not take her medication she did not care, then in a louder tone stated “Go”. When the resident was walking away AP #2 was recorded saying “you’re getting on my nerves, [pause] shit”. AP #2 made this statement loud enough for it to be picked up by the audio recording of the video.

During an interview AP #2 stated that morning the resident did not want to take her medications, so she put the resident’s medications in a bag within medication cart. AP #2 stated the resident then became aggressive and stated “ow, you’re hurting me” although AP #2 stated she was “barely” touching her. AP #2 stated she was aware of what verbal abuse was but denied saying ‘swear’ words to the resident.

During an interview, a manager, who had reviewed the recording, stated AP #2 spoke to the resident in a scolding way. The manager stated when this was brought to AP #2’s attention she did not understand how her actions were abusive.

A facility form provided indicated AP #2’s employment was terminated during the investigation interview.

In conclusion, the Minnesota Department of Health determined abuse was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.

“Substantiated” means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

Allegation #3

A concern arose that AP #3 abused the resident when video footage showed her turning a chair around so the resident could not sit beside her.

AP #3, an unlicensed caregiver, was working in the memory care unit the day of the incident but was not assigned to care for the resident that day.

The video footage provided began at 7:29 a.m. showed the resident walking towards AP #3, who was sitting in a chair looking at her phone. When the resident got closer to AP #3, she stated in a loud tone to the resident she needed to go sit on the couch and continued to turn the chair around so that the resident could not sit beside her. AP #3 went on to tell the resident "I'm sick, I don't want to get you sick" then the video footage ended.

During an interview AP #3 stated she was not trying to be unkind to the resident but was trying to redirect her because she didn't feel well that day.

During an interview the manager, stated she watched the resident wanting to sit down by AP #3, but she instead turned the chair around so the resident could not sit down beside her. She then attempted to redirect the resident to the TV area but did not get up and turned the TV on for the resident. The manager stated the behavior was discourteous to the resident.

In conclusion, the Minnesota Department of Health determined abuse was inconclusive.

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:

(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, unable due to cognitive impairment.

Family/Responsible Party interviewed: Yes

Alleged Perpetrators interviewed: Yes

Action taken by facility: The facility suspended the three unlicensed caregivers while completing an investigation. AP #1 and AP #2 were no longer employed at the facility. Additional training was provided to AP #3 and all the unlicensed caregivers at the facility.

Action taken by the Minnesota Department of Health: The facility was issued a correction order regarding the vulnerable adult's right to be free from maltreatment.

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 responsible party will be notified of their right to appeal the maltreatment finding. If maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc:

The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Ramsey County Attorney
Maplewood City Attorney
Maplewood Police Department
Minnesota Department of Human Services

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31968	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/08/2026
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NAME OF PROVIDER OR SUPPLIER MAPLE HILL SENIOR LIVING LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 3030 SOUTHLAWN DRIVE MAPLEWOOD, MN 55109
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(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
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0 000	<p>Initial Comments</p> <p>ASSISTED LIVING PROVIDER CORRECTION ORDER</p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation.</p> <p>Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance.</p> <p>INITIAL COMMENTS:</p> <p>#HL319683180C/#HL319689242M #HL319685960C/#HL319681460M</p> <p>On April 8, 2026, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 81 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued/orders are issued that were not issued at the time of immediate correction orders.</p> <p>The following correction order is issued/orders are issued for #HL319683180C/#HL319689242M, and #HL319685960C/#HL319681460M tag identification 2360.</p>	0 000		
02360	<p>144G.91 Subd. 8 Freedom from maltreatment</p> <p>Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial</p>	02360		

Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Minnesota Department of Health

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02360	<p>Continued From page 1</p> <p>exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act.</p> <p>This MN Requirement is not met as evidenced by: The facility failed to ensure one of one residents reviewed (R1) was free from maltreatment.</p> <p>Findings include:</p> <p>The Minnesota Department of Health (MDH) issued a determination maltreatment occurred on two separate investigaitons.</p> <p>For case #HL319683180C/#HL319689242M an individual person was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.</p> <p>For case #HL319685960C/#HL319681460M the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.</p>	02360		