Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL363688242M
Compliance #: HL363689327C

Date Concluded: February 25, 2026

Name, Address, and County of Licensee Investigated:
Goodneighbors Maplewood Manor
1010 1st Street NE
Elbow Lake, MN 56531
Grant County

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

Evaluator's Name: Barbara Axness, RN
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 perpetrator (AP), a facility staff member, abused the resident when she physically restrained him and barricaded him in a bathroom.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was inconclusive. There were conflicting accounts as to what happened between the resident and the AP. It was unable to be determined if abuse occurred. The AP admitted to secluding the resident in a bathroom for her safety and the safety of other residents. The resident was let out of the bathroom when police arrived.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement and the case manager. The investigation included review of the resident record, hospital records, facility

incident reports, personnel files, staff schedules, and law enforcement report. Also, the investigator observed the area where the incident occurred.

The resident resided in an assisted living facility. The resident's diagnoses included moderate dementia, agitation, bipolar disorder, schizoaffective disorder, and paranoid personality disorder. The resident's service plan included assistance with managing symptoms of delusions and paranoia. The resident's admission assessment indicated the resident had schizophrenia related to a past traumatic brain injury and had a history of expressing events that aren't true. The resident had a history of paranoia and delusions; however, no interventions were identified. Staff were to monitor for changes in mood or behavior and report to the nurse immediately.

The resident's record indicated he moved to the facility a few days prior to the day the altercation with the AP occurred. The resident's record lacked documentation of his first four days at the facility or if the resident had any behaviors. The resident's record included documentation that 911 had been called the day prior to the incident by the resident who reported that people were stealing his stuff, and he was not in a safe location. It was noted the resident had a sticker on his door that read "liars and thieves can stop taking my stuff." A facility nurse spoke with the resident's guardian about behaviors observed which included poor memory, paranoia, and smoking in a prohibited smoking area. No interventions related to the resident's behaviors were documented. Later that day, documentation indicated the AP called management to report the resident was having behaviors and being combative, so the manager came to the facility. The manager arrived around 7:00 p.m. and spoke to the resident, who was upset that staff were stealing his items. Documentation indicated the resident came to the memory care door and was yelling/accusing staff of stealing his items and the AP told him he needed to quit yelling and go back to his room. The resident then came to the front reception area and started yelling that he was going to slit the staff member's throat and called her a "fucking cunt." The staff member restrained the resident by putting him in the bathroom and holding the door closed. A bystander also helped hold the bathroom door closed and the resident was secluded in the bathroom for nine minutes.

The facility's incident report indicated the AP called management at 6:52 p.m. and stated the resident had physically assaulted her and the cops were on the way. The AP stated the resident accused the AP of stealing things and the AP told the resident he needed to quit yelling or he could go back to his room. The resident went back to his room, then came out to the main common area and told the AP she was a cunt, was screaming and yelling, and said he'd slit her throat. The AP restrained the resident by putting him into the bathroom and holding the bathroom door shut. A bystander helped the AP hold onto the door. The resident was restrained/barricaded in the bathroom from 6:37 p.m. to 6:46 p.m. when law enforcement arrived. The AP reported the resident was very strong and resistive to being barricaded in the bathroom.

Management reviewed available surveillance footage, and it was observed that during the altercation the resident did not appear to be physically resistive or displaying behavior indicative of violence toward the AP. It was noted that portions of the incident occurred in camera blind spots, during which no visual footage of the resident or AP was available. The AP was placed on suspension pending investigation and was later terminated. The facility's investigation did not include the original surveillance camera footage. Management interviewed the AP, a resident and a resident's daughter. A resident reported she saw a man making a phone call, but she did not hear any fighting. The resident reported seeing staff member put the resident in the bathroom. A resident's daughter heard noise coming from the common area and heard the AP yelling and observed the AP place the resident into the bathroom. The other resident's daughter assisted by holding the door until law enforcement arrived because the AP appeared distressed.

The police report indicated officers were called for a combative and out of control resident. Upon arrival, they observed staff members holding the knob of the bathroom door so the resident couldn't lock the door but also to keep distance from the resident. Officers were told the resident had confronted staff and accused the staff member of stealing items from his room. The resident became "enraged" and was yelling, pushing and swinging at staff members. The resident was noted to be a danger towards others. The resident was noted to have a skin tear so he was brought to the emergency room for evaluation for injury and his mental health. The AP reported to law enforcement that the resident was accusing staff of stealing things from his room, and was first yelling then came at her flailing his hands and striking her in the head, chest, and arms. The resident was yelling, "I'm going to kill you over and over." The AP reported to law enforcement that she was concerned for other residents so she grabbed ahold of his arm and directed him to the bathroom in the common area and held the doorknob so he could not lock it.

The AP's employee record was reviewed. The AP received all required training and was trained on de-escalation and mental health topics. The AP did not have a history of any disciplinary action.

During an interview, the AP stated she had been trained on interventions but didn't feel like staff had the proper training for dealing with the resident's mental health needs. The AP stated the resident frequently accused people of stealing from him and the evening of the incident, he thought she had stolen from him. The resident was very agitated and she called her manager to let her know the resident was threatening her. The AP stated the resident went to the common area to use the phone and when she approached him, he said he was calling the cops. The AP stated she told the resident he didn't need to do that, and she had already called her manager to report his concerns, and the resident slammed the phone down and began punching her about six times. The AP stated she put her hands up to stop the resident from punching her and put her hands around his arms to put them down. The AP stated she was afraid the resident was a danger to himself and the other residents, so she put him in the bathroom and held the door until the police arrived. The AP stated as soon as law enforcement arrived a few minutes

later, she let them take over and the resident came out of the bathroom. The AP stated she was evaluated in a clinic and sustained several bruises and scratches from the incident.

During an interview, a witness stated she came to the facility after a power outage in the independent living facility as the assisted living had a generator. The witness stated she couldn't recall all the details of the incident, but the resident was on the phone talking to someone and then he went and locked himself in the bathroom. The witness stated she thought the AP was trying to talk to the resident to calm him down and that she was worried the resident would hurt the AP. The witness stated she called 911 after the AP asked her to.

During an interview, a manager stated the AP gave conflicting accounts of what happened, and camera footage reviewed showed the AP grabbed the resident and put him in the bathroom. The manager stated the AP feared for her safety and the safety of other residents, but when they interviewed the other residents, they stated they felt safe. The manager stated they felt the AP abused the resident and the AP was not remorseful over the situation, did not feel she did anything wrong, and said she would do it again.

During an interview, the resident's guardian stated prior to his admission, she provided the facility with police reports and information about the resident's behaviors, including a history of angry outbursts. The resident's guardian stated she did not feel the facility could not manage the resident's mental health related behaviors, but management assured her they'd be able to care for him. The guardian stated the resident could be scary if he was coming at a staff member.

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;
(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; and

Vulnerable Adult interviewed: Yes
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The facility investigated the incident and reported it to MAARC. The AP was suspended pending investigation and later terminated. Additional interventions were added for the resident.

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
	36368	A. BUILDING: _____ B. WING _____	C 01/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLEWOOD MANOR LLC	1010 1ST STREET NE ELBOW LAKE, MN 56531

(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 January 6, 2026, the Minnesota Department of Health initiated an investigation of complaint #HL363689327C/HL363688242M. No correction orders are issued.	0 000		