Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL316206484M **Date Concluded:** November 25, 2025
Compliance #: HL316205425C

Name, Address, and County of Licensee Investigated:
Silvercreek on Main
8200 Main St North
Maple Grove, MN
Hennepin County

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

Evaluator's Name: Lena Gangestad, RN
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): The alleged perpetrator (AP) abused the resident by repeatedly ordering her to stand when she was not able to do so. He then grabbed her by the back and attempted to force her into a standing position. The AP subsequently handled the resident forcefully and threw her onto the bed.

Investigative Findings and Conclusion: The Minnesota Department of Health determined abuse was substantiated. The AP was responsible for the maltreatment. A video recording showed the AP handling the resident in a physically rough manner at the bedside while she verbally expressed pain and distress.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident's records, internal investigation documentation, incident reports, personnel files, staff schedules, policies, and procedures.

The resident resided in an assisted living secured memory care building. The resident's diagnoses include dementia. The resident's service plan included assistance with all activities of daily living. The resident's assessment indicated that she used a walker and a transfer belt for transfers and mobility.

A concern arose when a video was reviewed showing the AP transferring the resident improperly.

During the prior afternoon, the resident was found sitting on the floor in the hallway with her knees bent and her walker beside her while she was out with a family member inside the facility.

The progress notes indicated the nurse followed up with the resident after the fall and the family member assisted the resident to the room later. No injury was identified at that time.

At 11:37 later that same evening an unlicensed caregiver sent a message via the facility's snap message record [an internal electronic communication system for caregivers]. The unlicensed caregiver's message indicated the resident had fallen and was crying due to leg pain. It also indicated she was calling out to use the bathroom but was unable to ambulate, requiring staff to use a wheelchair throughout the shift, and advised staff to exercise caution. Consistent with the snap message, the facility's internal investigation later found the unlicensed caregiver verbally informed the AP during the evening-to-night shift handoff the resident had fallen earlier that afternoon and was experiencing some weakness.

At 12:21 a.m. on the following night shift, the snap message software indicated the AP viewed this message from the previous shift.

At approximately 3:20 a.m., video footage showed the AP positioned next to the bed while the resident was sitting at the side of the bed with the walker in front of her. The resident appeared to have difficulty going from a sitting position to standing.

The AP verbally instructed the resident multiple times to "stand up." He then placed his hand on the resident's back and attempted to assist her into a partially standing position. The resident vocalized "Ow" repeatedly and returned to a seated position on the bed.

The AP again instructed the resident twice to stand. He grasped the resident's clothing at the mid-back area with his left hand and held her arm with his right hand. During this interaction, the resident repeatedly vocalized "Ow" in a manner consistent with discomfort or pain.

The AP then made a statement referencing "going to the bathroom" and turned the resident's walker so her right hand remained on the walker, but her left hand could not reach it. The resident cried out and fell forward onto her knees.

The AP then lifted the resident and placed her partially onto the bed all while the resident was crying out. At one point, the resident torso drops onto the mattress with an audible thud recorded by the video's audio with her legs bent and crumpled towards the floor.

The AP repeatedly stated, "Nope, nope, nope," while lifting the resident and dropping her onto the mattress with enough force the noise made by the impact on the mattress was audibly recorded on the video. The resident continued panting and crying out while he repositioned her into sitting at the side of the bed. The resident cried out "Oh, please."

When the resident reached toward the AP's leg, the AP pushed her arm away. He then lifted her legs and positioned her in a lying position on the bed, adjusting her legs and body. The resident continued to moan and pant throughout the interaction. As the video ended, it showed the AP preparing to change the resident's incontinence pad.

During an interview, a nurse stated a caregiver reported the resident was in pain on the following day shift. The family member was notified and, at the same time, provided the facility with the video footage of the incident that occurred during the night. The nurse said the resident was reassessed and the AP was suspended. The nurse stated when she interviewed the AP, he admitted he did not use a gait belt during the transfer. She stated he did not complete an incident report and did not notify anyone about the incident. The AP told her he was not aware of the resident's earlier fall.

During an interview, the AP stated he was unaware the resident had fallen earlier in the day. The AP stated when he asked the evening staff whether there was anything he needed to know, she told him no. He said during his first round, he entered the resident's room to assist her to the bathroom, and she did not want to get up. He stated he tried to help her stand, but she sat back down on the bed and howled loudly. He stated she then slumped to the side, and he "grabbed her and pushed her over the bed." He said he "grabbed her, put her over the bed, and completed her care." On his last round he entered the room, and the resident showed him her legs were sore. He completed her care and informed the nurse the resident complained of leg soreness. The nurse then told him the resident had fallen the night before. He stated he had not been told about the fall and did not see it in the report. He stated the resident did not fall; rather, she "just leaned on the bed." He stated he would never allow her to fall to the floor. The AP stated he had worked there for ten years.

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.

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; or
(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 unless authorized under applicable licensing requirements or Minnesota Rules, chapter 9544.

Vulnerable Adult interviewed: No, the resident had dementia.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility: After the nurse viewed the video, she assessed the resident and notified the nurse practitioner. An ice pack was applied to the resident's left knee, and pain medication was administered. After updating the medical provider, the resident was transported to the hospital for further evaluation via 911. The facility retrained staff members regarding reporting requirements, fall protocols, and dementia-appropriate approaches using compassionate care. An audit was initiated to prevent recurrence.

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 the 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
Hennepin County Attorney
Maple Grove City Attorney
Maple Grove Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31620	A. BUILDING: _____ B. WING _____	C 10/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVERCREEK ON MAIN	8200 MAIN STREET MAPLE GROVE, MN 55369

(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 October 23, 2025, the Minnesota Department of Health initiated an investigation of complaint HL316206484M/HL316205425C. The following correction order is issued, tag identification 2360.	0 000		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual perpetrator was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360	No plan of correction is required for this tag.	