*Protecting, Maintaining and Improving the Health of All Minnesotans*

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** HL354892440M
**Compliance #:** HL354898823C

**Date Concluded:** June 2, 2026

**Name, Address, and County of Licensee Investigated:**
Suite Living of North St. Paul
2710 13th Avenue East
North St Paul, MN 55109-3115
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):**
The alleged perpetrator (AP) abused the resident when the resident fell and sustained serious injuries and later died.

**Investigative Findings and Conclusion:**
The Minnesota Department of Health determined abuse was substantiated. The AP was responsible for the maltreatment. While the AP initially reported he was not in the room when the resident fell, that report was inaccurate, and the AP was present in the room. A fellow caregiver who heard the AP and the resident interact later said the AP was being aggressive and pushed the resident resulting in the fall. Additionally, the AP contacted two fellow caregivers to create a false narrative regarding the incident.

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

records, facility internal investigation, facility incident reports, personnel files, staff schedules, law enforcement report, and related facility policy and procedures. Also, the investigator observed staff and resident interactions during an onsite visit.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia. The resident's service plan included assistance with medication management, providing cues and reminders for orientation, completing activities of daily living and safety checks every 2 hours. The assessment indicated the resident was able to walk independently, was resistant to care and required redirection due to behaviors.

A concern arose when it was reported to the nurse the resident did not fall but was pushed by the AP when he was found on the floor and sustained injuries the week prior.

The day of the incident unlicensed caregiver #1, had worked the overnight shift and was still on the memory care unit to complete documentation. The AP and unlicensed caregiver #2 were working the day shift on the memory care unit.

A facility incident report completed by the AP on the day of the incident indicated the AP was walking by and saw the resident on the floor.

However, a week later when the nurse was notified the incident report may not be accurate, she decided to review the video footage as part of a facility investigation. The facility investigation report indicated video footage contradicted the incident report.

The facility video footage showed the AP entering the resident's room at 6:18.36 a.m. While in the resident's room, the AP's voice could be heard stating "take a seat, take a seat" then next "[inaudible words] kill you" followed by a loud thud and the resident yelling out "Ow, oh, oh, oh, my back" and "you're killing me, you're killing me." The video showed the AP exit the resident's room at 6:20.20 a.m. When the AP left the resident's room, unlicensed caregiver #1 could be heard asking "did he fall?"

The facility investigation indicated unlicensed caregiver #1 stated she heard the resident hit the wall "super hard," too hard for the resident to have fallen. The same report indicated unlicensed caregiver #1 stated the AP pushed the resident because he was upset the resident was incontinent of stool.

A law enforcement report indicated the AP stated when he started the day at around 6 am, he found the resident incontinent and naked. He asked unlicensed caregiver #1 to assist but she declined to help. The AP stated he was not in the room when the "thud" was heard, but it sounded like "a large item" and "something big hit the wall." When the AP was confronted with video footage that conflicted with his story, the AP later admitted to being in the room when the resident fell.  A law enforcement report indicated that unlicensed caregiver #1 stated the AP was being aggressive with the resident and that the AP pushed the resident. Unlicensed

caregiver #1 stated the AP was known for being aggressive with residents. The law enforcement report indicated when interviewed, unlicensed caregiver #2 stated days later, the AP had called and asked her to say they were together when the resident fell. Unlicensed caregiver #2 stated the AP tried to contact her again a few days later to change her story to match his, that they were together when the resident was found on the floor. Unlicensed caregiver #2 stated she told the AP everything was on camera.

During an interview, the nurse stated she was told by unlicensed caregiver #3 that unlicensed caregiver #1 stated the AP pushed the resident caused the fall. The nurse stated the facility began an investigation which included a review of video footage. The nurse stated she had reported concerns that the residents appeared to be afraid of the AP and some residents referred to the AP as “the devil” to the previous housing manager but was not aware if an investigation was completed. The nurse reported during a recent stand-up meeting, the AP asked her what he could do if a resident hit him. The nurse instructed the AP he should walk away, to which the AP replied that he works in a prison and there they can “restrain them or slam them to the ground if they hit you.” The nurse told the AP he could not do that to elderly residents.

During an interview, unlicensed caregiver #1 stated she worked the night before the incident. Unlicensed caregiver #1 stated the AP was in the resident’s room and she heard the two yelling back and forth, but the door was closed, and she could not see anything. She then heard a loud noise “like something hitting the wall” and when the AP opened the door, she could see the resident was on the floor with his back against the wall and his legs in front of him, which she didn’t feel would be consistent with a fall. Unlicensed caregiver #1 stated the AP later texted and called her to corroborate his story when she made a written statement.

During an interview, unlicensed caregiver #2 stated she was working the day of the incident but was in a room with another resident. When she finished and came out to the desk, she was told the resident was on the floor. Unlicensed caregiver #2 asked how the resident fell, and the AP only responded, “he fell.” Unlicensed caregiver #2 stated where the resident was found, and how he was positioned was not consistent with a fall. Unlicensed caregiver #2 stated later the AP called her and told her to say they were together when the resident was found on the floor.

During an interview, unlicensed caregiver #3 stated she was not present at the time of the incident but later worked with unlicensed caregiver #1 who told her on the day of the incident, the AP was yelling back and forth with the resident, then she heard a “boom”, and felt the AP had pushed the resident. Unlicensed caregiver #3 stated she reported the information to the nurse and went on to say she had previously reported concerning information about the AP to the same nurse.

During an interview, the AP stated when arriving on the unit for his shift, the resident was incontinent and unlicensed caregiver #1 refused to help clean the resident. The AP stated when

attempting to clean the resident, he “spun away and then fell on his butt” then he began shouting that the AP was trying to kill him. The AP denied pushing the resident.

Hospital records indicated the resident suffered a fractured pelvis and a fractured rib. Three days later, the resident returned to the facility with hospice for end-of-life care. The resident did not walk again after returning to the facility and died 17 days later.

The cause of death was documented as probable complications of a pelvic fracture after a fall.

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:
(a) An act against a vulnerable adult that constitutes a violation of an attempt to violate, or aiding and abetting a violation of:
(1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224;
(2) the use of drugs to injure or facilitate crime as defined in section 609.235;
(3) the solicitation, inducement, and promotion of prostitution as defined in section 609.322; and
(4) criminal sexual conduct in the first through fifth degrees as defined in sections 609.342 to 609.3451.
A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.
(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.
(c) Any sexual contact or penetration as defined in section 609.341, between a facility staff person or a person providing services in the facility and a resident, patient, or client of that facility.
(d) The act of forcing, compelling, coercing, or enticing a vulnerable adult against the vulnerable adult's will to perform services for the advantage of another.

**Vulnerable Adult interviewed**: No, the resident is deceased
**Family/Responsible Party interviewed**: Yes
**Alleged Perpetrator interviewed**: Yes

**Action taken by facility:**
The facility investigated the incident, notified law enforcement and later terminated the AP.

**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
Ramsey County Attorney
North St. Paul City Attorney
North St. Paul Police Department
Minnesota Department of Human Services – Licensing
Department of Human Services (DHS) Background Study Unit

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 35489 | A. BUILDING: _____ B. WING _____ | C 05/14/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SUITE LIVING OF NORTH ST PAUL | 2710 13TH AVENUE EAST NORTH SAINT PAUL, 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<br><br>******ATTENTION******<br><br>HOME CARE PROVIDER/ASSISTED LIVING PROVIDER CORRECTION ORDER<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation.<br><br>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.<br><br>INITIAL COMMENTS:<br><br>#HL354898823C/#HL354892440M and #HL354896240C/#HL354891542M<br><br>On May 14, 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 27 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued.<br><br>No correction orders were issued for #HL354896240C/#HL354891542M. The following correction order is issued for #HL354898823C/#HL354892440M, tag identification 2360. | 0 000 | | |
| 02360 | 144G.91 Subd. 8 Freedom from maltreatment<br><br>Residents have the right to be free from physical, | 02360 | | |

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|---|---|---|---|---|
| 02360 | Continued From page 1<br>sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act.<br><br>This MN Requirement is not met as evidenced by:<br>The facility failed to ensure one of one resident reviewed (R1) was free from maltreatment.<br><br>Findings include:<br><br>The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and 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. | 02360 | Assisted Living Provider 144G.<br>Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction.<br><br>PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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|---|---|---|---|---|
| 02360 | Continued From page 2 | 02360 | ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3. | |