Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL319681460M
Compliance #: HL319685960C

Date Concluded: June 2, 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, facility 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 facility neglected the resident when ordered medications were missed for 5 days and the resident had increased confusion and was transported to the hospital.

Investigative Findings and Conclusion: The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility received notice the resident's medications would not be delivered due to billing issues but did not take timely steps to address the billing issues. Additionally, once the resident's medications ran out the facility did not administer the medications for five days nor did the facility update the resident's medical provider.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the pharmacy, the medical provider and the hospital for records. The investigation included review of the resident record, hospital records, pharmacy records, internal facility investigation, facility incident reports,

personnel files, staff schedules and related facility policy and procedures. Also, the investigator observed resident and staff interactions during an onsite visit.

The resident resided in an assisted living facility. The resident's diagnoses included Alzheimer's disease, type 2 diabetes, atrial flutter and chronic pain. The resident's service plan included assistance with medication management and administration, checking blood sugar levels every morning and safety checks. The resident's assessment indicated that he had intermittent confusion and walked with a walker.

A concern arose when the resident missed five days of medications and was admitted to the hospital.

On the 7th day of the month, approximately two and a half weeks prior to the resident's hospitalization, a progress note indicated the facility received notification from the pharmacy that the resident's account was on hold for unpaid balances.

On the 20th day of the month, the EMAR indicated the facility did not administer many of the resident's medications for five consecutive days (the 20th through the 24th day of the month. Those medications included:

- Aripiprazole: medication to improve mood
- Duloxetine: medication to treat depression
- Eliquis: medication to thin the blood
- Furosemide: medication to get rid of extra water
- Gabapentin: a medication to treat nerve pain
- Lisinopril: a medication to treat high blood pressure
- Memantine: a medication to treat memory loss
- Metformin: a medication to lower blood sugar
- Sodium Chloride: a medication to maintain sodium levels

On the 21st day of the month, the resident's progress notes indicated the resident was sent to the hospital for evaluation of not feeling well, shaky and high blood pressure. However, the resident was not admitted on this occasion but rather returned to the facility the same evening.

On the 22nd day of the month the progress notes indicated the facility update the medical provider the resident had a decrease in physical ability and requested an order for physical and/or occupational therapy. However, a review of the progress notes found no indication the facility informed the medical provider the resident was not receiving medications as prescribed.

On the 23rd day of the month the progress notes indicated the facility contacted the resident's family member regarding his medications that were on hold at the pharmacy and provided the

family member with the pharmacy's billing contact. Later that same day the progress notes indicated a seven-day supply of all medications would be sent by the pharmacy.

Also, on the 23rd day of the month, the progress notes indicated the facility contacted the medical provider about the resident's wandering and increased confusion. The medical provider provided an order for physical and occupational therapy. However, a review of the progress notes found no indication the facility informed the medical provider the resident was not receiving medications as prescribed.

On the morning of the 24th day of the month, the progress notes indicated the resident's daughter called for emergency medical services (EMS) after she noticed the resident experiencing increased confusion during a phone call.

Later the same day, the progress notes indicated the hospital reached out to the facility to review the resident's medications and the last dose given. The resident was admitted to the hospital.

The hospital records indicated the resident was admitted with diagnoses including hyponatremia (low sodium levels), shortness of breath, and high blood sugars.

The manufacturer's website for Eliquis indicated the following: Some important safety information to know about ELIQUIS is: (1) Do not stop taking ELIQUIS without talking to the doctor who prescribed it for you. For patients taking ELIQUIS for atrial fibrillation: stopping ELIQUIS increases your risk of having a stroke.

During an interview, a nurse stated the resident's insurance had lapsed and a debt accrued at the pharmacy. The pharmacy then placed collections hold and would not fill the resident's medications until payment was received. The nurse stated the resident missed medications for 5 days and went to the ER twice during the five days, once on day 2 and again on day 5. The nurse was unsure whether the medical provider was notified the resident missed ordered medications and stated a medication error report was not completed. The nurse stated the pharmacy had previously sent emails to her and another nurse regarding issues dealing with medications, and now she has all nurses notified of issues.

During an interview, the medical provider stated the facility did not notify them of the resident missing medications. The provider stated notifications from the facility were documented in their portal on day three, four and five, reporting a physical decline, increased behaviors and increased confusion. The provider stated the nurse did not notify the provider of the resident missing medications during any of the notifications. The provider stated she was unaware of the missing medications before the interview, however in retrospect the symptoms reported would be consistent with the ordered medications not being administered and potentially could have been the reason for hospitalization.

In conclusion, the Minnesota Department of Health determined neglect 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.

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: attempted but unable due to cognitive impairment
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility: Facility arranged for medications to be filled by pharmacy, then implemented new processes to monitor when medications are not available for administration.

Action taken by the Minnesota Department of Health: The responsible party will be notified of their right to appeal the maltreatment finding.

The facility was found to be in noncompliance. 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

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

You may also call 651-201-4200 to receive a copy via mail or email

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

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 04/08/2026

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 ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. 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. INITIAL COMMENTS: #HL319683180C/#HL319689242M #HL319685960C/#HL319681460M 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. The following correction order is issued/orders are issued for #HL319683180C/#HL319689242M, and #HL319685960C/#HL319681460M 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	02360		

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02360	Continued From page 1 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 residents reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred on two separate investigaitons. 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. 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.	02360		