Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL306892542M
Compliance #: HL306894467C

Date Concluded: July 22, 2025

Name, Address, and County of Licensee Investigated:
Boden Senior Living
11372 Robinson Drive
Coon Rapids, MN 55433
Anoka County

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

Evaluator's Name: Lissa Lin, 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) neglected the resident after she had an unwitnessed fall at her bedside. The AP did not report the fall or the resident's complaint of arm pain. The nurse sent the resident to the hospital where she was diagnosed with an arm fracture.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The AP failed to follow the facility's fall protocol when she found the resident seated on her bedroom floor. The AP roughly lifted the resident off the floor and put her back to bed, ignoring the resident's multiple cries of pain. The AP failed to notify the nurse of the resident's fall and injury.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family member. The investigation included review of resident records, hospital records, facility incident reports, personnel files, staff schedules, related facility policy and procedures and video clips from the

family electronic monitoring device. Also, the investigator observed the resident in the memory care common area relaxing with other residents.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia, osteoarthritis of knee and hip, and age-related osteoporosis. The resident's service plan included assistance with bathing and toileting, safety checks, and escorts to meals. The resident's assessment indicated she had cognitive decline and confusion. She had a history of falls and fractures.

A progress note indicated the resident reported she had a fall. The nurse updated the resident's family who would review the camera to see if she had an unwitnessed fall and was able to get herself back up.

An incident report indicated the resident was seen on camera at 9:30 a.m. on the floor next to her bed. She had slowly slid off her bed to the ground. During a internal investigation, the AP stated she was aware the resident had pain, but said "she has shoulder pain" and her fall would not have hurt her shoulder. The AP stated she helped get the resident off the floor and notified the nurse after lunch. The AP said she did not think the resident had a "real" fall.

Review of several video clips from an electronic monitoring device showed the resident lowered herself to the floor and sat with her back resting against her bed. The AP entered the resident's room and said, "get up." The AP approached the resident, bent over her, placed her hands under the resident's armpits and pulled the resident up to her feet. The resident said "ow" several times as she stood. The resident struggled to hold her wheeled walker handlebars. The AP directed her to move back to her bed. She grasped the back of the resident's pants and shirt and pulled the resident backwards to the edge of her bed. The resident sat slumped on the edge of the bed. The AP said, "lie down now." She lifted the resident's legs with one arm and rolled her into bed onto her right side. The resident said "ow" several times. The AP pulled a blanket up over the resident, said "You're okay." and exited the room.

A progress notes the next day indicated the resident experienced increased pain and bruising on the right arm. Bruising also developed on the right side of her forehead. The facility sent her to the hospital for evaluation.

Hospital records indicated the resident had a fractured right humerus and bruised forehead. She was treated and released from the hospital with palliative care. She still had rehabilitation treatments.

During an interview, the nurse said the AP told her the resident complained of pain, had an unwitnessed fall and got herself up from the floor. The AP did not tell her the resident slid to the floor and the AP put her back up on the bed and left her. The nurse said the AP was a long-time employee and trained on their fall protocols. The nurse said she did not learn about the resident's fall until the afternoon. She assessed the resident, who denied pain at the time.

The nurse called the physician and family member. The next day the resident complained of pain and bruising was noted on her arm. The nurse called 911 and had the resident sent to the hospital. The nurse said the resident's arm fracture could have happened two days earlier when the resident stumbled and fell in the common area while dancing. Other memory care residents helped her back to her feet, but did not report the fall to any staff members. The nurse saw the fall that while reviewing a few days of memory care common area camera footage to determine what happened to the resident that she sustained a bump on her head and an injured arm.

During an interview, the AP said she saw the resident on the floor, but she did not look like she fell. She asked the resident what happened and took her vitals. She asked the resident if she could get up on her own and the resident said yes. The AP sad she got the resident back up onto her bed, changed her wet adult brief, and then went and wrote a note in the communication book on how she found the resident. The AP said the fall protocol is to use a Hoyer mechanical lift if staff find a resident lying on the floor. The AP said the resident was seated on the floor and seemed fine. She was suspended two days, then terminated.

The resident's family member said the AP's behavior toward the resident was concerning. She said the resident sat down on the floor with intention, she did not fall, but when the AP entered the room about 15 minutes later, she just threw the resident on the bed. The family member said the AP was aggressive and lacked empathy. While the AP's actions were her main concern, the family member said other staff members who came into the resident's room during the day were "dismissive" when the resident she said she fell and had shoulder pain. The family member said all staff members should pay attention to memory care residents if they say they fell or have pain.

The resident was not interviewed due to cognition.

Facility guidelines for falls and fall prevention instructed staff members to use a full mechanical lift to transfer a resident off the floor if the resident was unable to independently transfer self-off the floor with or without verbal cues and or physical device.

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.

Mitigating Factors considered, Minnesota Statutes, section 626.557, Subd. 9c(f):

(1) The AP did not follow an erroneous order, direction or care plan with awareness and failure to take action.

The facility did not direct an erroneous order, direction, or care plan.

(2) The facility was not in compliance with regulatory standards.

The facility provided proper training and/or supervision of staff.

The facility provided adequate staffing levels.

The AP failed to follow the facility directive and/or policies and procedures.

(3) The AP failed to follow professional standards and/or exercise professional judgement.

The AP failed to act in good faith interest of the vulnerable adult.

The maltreatment was not a sudden or foreseen event.

Vulnerable Adult interviewed: No due to cognition.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The resident was sent to the hospital for evaluation and treatment. The AP is no longer employed 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.

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

Anoka County Attorney
Coon Rapids City Attorney
Coon Rapids Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30689	A. BUILDING: _____ B. WING _____	C 06/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BODEN SENIOR LIVING - COON RAPIDS	11372 ROBINSON DRIVE NW COON RAPIDS, MN 55433

(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 ******ATTENTION****** 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: HL30689447C/HL306892542M HL30894409C/HL306892502M On June 17, 2025 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 45 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for HL30689440[illegible]/HL306892502M, tag identification 0730. The following correction order is issued for HL30689447C/HL306892542M, tag 2360.	0 000	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. 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. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the	0 730		

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0 730	Continued From page 1 following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution;	0 730		

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0 730	Continued From page 2 (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on record review and interviews, the licensee failed to ensure the contents of a resident record included contact information for medical providers and documentation of significant changes in the resident's status and actions taken for one of two residents (R2) reviewed. R2's record lacked documentation that nursing staff attempted to contact the wound care provider for regular updates on R2's leg wounds and complex wound dressings. R2 was hospitalized with sepsis and died. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R2's facesheet lacked contact information or the name of R2's wound care medical provider. R2's medical diagnoses include paraplegia, cellulitis of left lower limb and chronic kidney disease. R2 used an electric wheelchair.	0 730		

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0 730	Continued From page 3 R2's nursing assessment dated April 21, 2025, indicated in the Skin Integrity section she had an open area wound and in the description section: "unable to assess as complex wound dressing in place with ortho boot, resident gets wound care weekly at clinic." R2's service agreement dated April 23, 2025, indicated R2 received staff assistance of two for mechanical lift transfers, toileting and dressing assistance and safety checks. R2 was assessed by the nurse as able to make her needs known and make her own decisions. A progress note by director of health services (DHS)-A dated April 23, 2025, at 4:44 p.m., indicated R2 returned from wound clinic, did not provide any paperwork from visit but reported the doctor did wound cares to her legs and buttocks. New antibiotic, clindamycin 300 milligrams by mouth twice a day for 14 days started. A progress note by DHS-A dated April 24, 2025, at 1:11 p.m., indicated a call was placed to R2's foot care doctor office to clarify antibiotic orders. R2 had two antibiotics, levaquin and clindamyin. Staff from the foot care office reported the doctor did not address wounds above the knees. A progress note by DHS-A dated April 25, 2025, at 1:16 p.m., indicated DHS-A called R2's PCP to provide an update to buttocks wounds, requested home care and wound care services until buttock wounds healed. A progress note by DHS-A dated April 28, 2025 at 10:42 a.m., indicated R2 appeared confused and had low blood pressure and low oxygen saturation rate. Emergency medical services was called and took R2 to the hospital. A progress	0 730		

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0 730	Continued From page 4 note dated April 28, 2025, at 4:10 p.m., indicated R2 was in kidney failure. A progress note by DHS-A dated April 29, 2025 at 5:47 p.m. indicated R2 died at the hospital. R2's leg wound was managed by an outside provider routinely every week was not getting good blood flow. R2's antibiotics were not getting to the site of infection, causing sepsis per the hospital, and this caused R2's kidneys to fail. During an interview on June 17, 2025, at 9:20 a.m., DHS-A said R2 was very independent and had few services. She had her leg wounds and treatments long before she admitted to the licensee. R2 did not tell staff when she went to see providers and did not give them paperwork after visits. R2 had both legs wrapped and would not let nursing staff assess them. During an interview on June 25, 2025, at 12:01 a.m., DHS-A said she verified that R2 went to a wound clinic with R2's family member and the clinic. DHS-A said R2 told staff only the wound doctor could unwrap and redress her leg wounds. DHS-A said she saw one of R2's leg wounds once over one year ago and it was down to the bone. A Change in Condition Guideline, revised May, 2024, indicated a change in condition can include the presence of a wound requiring treatment and monitoring. Daily monitoring; RN to assess changes and document in resident record. TIME PERIOD TO CORRECT: Twenty-one (21) Days	0 730		

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02360	Continued From page 5	02360		
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 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		