Protecting, Maintaining and Improving the Health of All Minnesotans

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** HL387432682M
**Compliance #:** HL387434648C

**Date Concluded:** August 12, 2025

**Name, Address, and County of Licensee Investigated:**
Boden Senior Living
5399 155th Street West
Apple Valley, MN 55124
Dakota County

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

**Evaluator's Name:** Danyell Eccleston, RN
Special Investigator

**Finding:** Not Substantiated

**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), facility staff, abused the resident when the AP drugged and sexually assaulted the resident. The resident went to the hospital for follow-up evaluation after reporting she was unusually groggy and felt possibly drugged and assaulted.

**Investigative Findings and Conclusion:**
The Minnesota Department of Health determined abuse was not substantiated. Hospital exam results indicated drugs found in the resident's system at the time of exam were drugs that were prescribed to the resident and only the resident's DNA was found in lab results. The resident later stated she did not believe she was sexually assaulted.

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 records, facility internal investigation, facility incident reports, personnel files, staff schedules, law enforcement report, related facility policy and procedures. Also, the investigator observed staff members interacting, providing care administering medications, and documenting medication administration to residents.

The resident resided in an assisted living facility. The resident's diagnoses included bipolar disorder and chronic pain disorder. The resident's service plan included assistance with medication administration and monitoring of reactive behaviors in a supportive environment. The resident's assessment indicated the resident's cognitive function was intact and was able to communicate needs and understand others. The resident's assessment also indicated the resident had moderate distress concerning the belief others were planning to harm her.

Review of progress notes indicated the day in question, the resident reported to an evening nurse she slept all day after taking her medications and had never slept like that before. The resident stated she had pain in her vagina like she was sexually abused and requested to be tested and examined. Emergency services were contacted and the resident went to the emergency room for evaluation. Review of progress notes the following day indicated the resident came back to the facility and the hospital diagnosed the resident with a urinary tract infection and ordered an antibiotic for treatment.

Review of law enforcement repot indicated the resident stated after eating crackers and drinking a soda that were stored in her apartment, she began to feel "groggy" and "passed out," staying asleep until late afternoon. The resident communicated it was unlike herself to sleep so much and that she felt drugged and after awakening she had vaginal soreness. The resident stated sometime while she was sleeping the AP woke her up and gave her medications and that she was not sure if the AP would have sexually assaulted her, however, there had been an instance a month prior when the AP was working that the resident felt drugged.

Review of a supplemental law enforcement report indicated the resident stated she did not eat before taking medication on the day in question and is supposed to take the medication with food. The resident stated she ate crackers and drank soda about an hour after taking medication and later woke when the AP was in her apartment. The resident reported feeling cold and the AP handed the resident pants and a shirt to change into and assisted the resident in dressing. The resident stated the AP gave the resident medication and then the resident laid back down and went to sleep again.

Review of additional supplemental law enforcement report indicated lab test results revealed only prescribed medications were found in the residents system

Review of sexual assault examination lab results indicated only the resident's DNA was present in swab testing.

Review of facility internal investigation report indicated the AP reported the resident said she was more tired than normal on the day in question. The AP reported the resident did not go down to lunch because she was in bed and later that day reported not feeling well. The AP informed the nurse and the nurse went to see the resident. The AP reported administering medications to the resident. Before end of day shift the AP checked on the resident and saw the resident sleeping. The facility internal investigation report indicated a medication administration error involving the AP was found, but did not include further details regarding the error.

During interview, a nurse stated the AP requested the nurse come see the resident during the afternoon of the day in question because the resident reported feeling unwell. The nurse stated the resident reported feeling dizzy and the nurse instructed the resident to rest and that the next shift nurse would follow up with the resident because the resident had a history of occasional dizziness.

During interview, a second nurse stated the evening of the day in question the resident indicated she reported feeling drugged during the day. The resident also indicated she had vaginal discomfort and felt like she had been abused. The nurse stated he contacted emergency services and facility leadership and the resident went to the hospital for evaluation. The nurse also stated when reviewing the resident's medication administration record, it appeared the AP made a medication documentation error and did not document medication administration of narcotics in both the narcotic log and medication administration record.

During interview, the AP stated she cared for the resident during the day and contacted the nurse when the resident requested to see a nurse. The AP stated she gave the resident prescribed medication when the nurse was in the room and then left to complete other tasks. The AP stated she did not think anything was unusual because the resident often had complaints or wanted to talk with a nurse. The AP denied drugging the resident or sexually abusing the resident. The AP stated the nurse was in the room during time of afternoon medication administration and it is possible she made a medication documentation error after administering afternoon medications.

During interview, the resident stated she did not typically have issues with feeling groggy after taking medication and wondered if she was drugged or received too much medication. The resident stated she no longer believed she was sexually assaulted and felt safe at the facility.

In conclusion, the Minnesota Department of Health determined abuse was not substantiated.

**"Not Substantiated" means:**
An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment did not occur.

**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**: Yes.
**Family/Responsible Party interviewed**: No, resident is own decision maker and requested family not be interviewed.
**Alleged Perpetrator interviewed**: Yes.

**Action taken by facility:**
Facility conducted an internal investigation of the allegation.

**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

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 38743 | A. BUILDING: ______<br>B. WING ______ | C<br>07/14/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **BODEN SENIOR LIVING APPLE VALLEY** | **5399 155TH STREET WEST**<br>**APPLE VALLEY, MN 55124** |

| (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>On July 14, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL387434648C/#HL387432682M. No correction orders are issued. | 0 000 | | |

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE