Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL387439362M
Compliance #: HL387438223C

Date Concluded: March 21, 2025

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

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

Evaluator's Name: Deb Schillinger RN BSN, 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 facility neglected the resident when the resident went outside to smoke in dangerously cold weather.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The resident was independent in decision-making and chose to go off campus to smoke.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the family member. The investigation included review of the resident record, facility internal investigation, facility incident reports, staff schedules, and related facility policy and procedures. Also, the investigator observed facility staff members and resident interactions during an onsite visit.

The resident resided in an assisted living facility. The resident's diagnoses included osteoporosis. The resident's service plan included assistance with medication management and administration. The assessment indicated the resident was independent in decision making and ambulated with using a walker. The documents also indicated the resident did smoke cigarettes.

A facility incident report indicated the resident reported she had an unwitnessed fall off the facility premises while smoking but was not injured. The resident's family member and medical provider were notified.

The residents medical record contained an entry indicating reeducation was provided to the resident related to hazards smoking, including health issues, danger of smoking in weather extremes and that emergency pendent system does not work outside of facility. When the resident was asked to stay inside, she declined and stated "no, I am going outside".

The residents service contract indicated the resident was informed of the prohibition of smoking on the facility premises.

The facility Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) indicated supervision of smoking was not an available service provided at the assisted living facility.

During an interview, a manager stated the resident was aware the facility was a non-smoking campus and was able to make her own decisions. The manager stated the resident reported she had an unwitnessed fall, off campus, without injury. Re-education was provided to the resident; however, the resident made the decision to continue to go off campus to smoke.

During an interview, the resident confirmed she was aware smoking was not allowed when she moved into the facility.

In conclusion, the Minnesota Department of Health determined neglect 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.

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.
(d) For purposes of this section, a vulnerable adult is not neglected for the sole reason that:
(1) the vulnerable adult or a person with authority to make health care decisions for the vulnerable adult under sections 144.651, 144A.44, chapter 145B, 145C, or 252A, or sections 253B.03 or 524.5-101 to 524.5-502, refuses consent or withdraws consent, consistent with that authority and within the boundary of reasonable medical practice, to any therapeutic conduct, including any care, service, or procedure to diagnose, maintain, or treat the physical or mental condition of the vulnerable adult, or, where permitted under law, to provide nutrition and hydration parenterally or through intubation; this paragraph does not enlarge or diminish rights otherwise held under law by:

Vulnerable Adult interviewed: Yes
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
Re-education was provided to resident

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38743	A. BUILDING: _____ B. WING _____	C 03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BODEN SENIOR LIVING APPLE VALLEY	5399 155TH STREET WEST 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 On March 18, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL387438223C/#HL387439362M. No correction orders are issued.	0 000		