Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL257293468M
Compliance #: HL257292858C

Date Concluded: October 28, 2026

Name, Address, and County of Licensee Investigated:
Select Senior Living
11350 Martin Street NW
Coon Rapids, MN 55433
Anoka County

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

Evaluator's Name: Lori Pokela R.N.
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 resident was neglected after the resident fell and was found with multiple rib fractures and pressure ulcers.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. When staff were alerted to the resident's fall and complaints of pain, the resident was assessed and sent to the hospital for further evaluation. The resident was diagnosed with acute rib fractures, prescribed pain medication and therapy services and discharged back to the facility. While at the hospital a blister was observed on the resident's heel. The resident's heel area was assessed and treated by a physician following her return to the facility and an outside wound care agency assumed management of the resident's wounds.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident record(s),

hospital records, facility incident reports, personnel files, staff schedules, related facility policy and procedures. Also, the investigator observed wound treatment and resident care provided by facility staff at the time of the onsite visit.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia, osteoporosis and osteoarthritis. The resident's service plan included assistance with activities of daily living (ADL) that included: dressing, toileting, medication management, bed mobility and daily safety checks. The resident's assessment indicated the resident was oriented to person with intermittent confusion and had a history of refusing cares. The resident's assessment indicated the resident needed staff assistance for bathing, dressing, grooming and daily skin monitoring.

Facility documentation indicated the resident was found on the floor of her bathroom and complained of pain in her left rib area. Staff reported the fall to the nurse who assessed the resident and transported the resident to the hospital for medical evaluation.

The resident's hospital medical records indicated the resident admitted to the hospital and diagnosed with multiple left-sided rib fractures and a small left pleural effusion (an abnormal buildup of excess fluid in the space between your lungs and your chest wall). While hospitalized, staff observed an intact blister on the resident's right heel. The resident discharged back to the facility approximately four days later with orders for occupation therapy(OT), Physical therapy (PT), pain medication, activity restrictions and chest injury care.

The resident's medial records indicated the resident was assessed by a nurse the day she returned from the hospital. The medical records indicated the resident's provider assessed the resident the following week and observed a pressure wound on each of the resident's heels. The provider treated both wounds, wrote orders for daily wound treatment and directed staff to elevate the resident's heels to relieve pressure. In addition, the provider requested for a wound care agency nurse to assess and treat the heel wounds.

Wound care agency staff assessed the resident three days later and then made weekly visits while facility staff provided wound care two additional times per week. Two weeks later, the resident's left heel wound resolved. Facility staff and the wound care nurse continued to care and monitor the resident's right heel wound.

During an interview, a management nurse confirmed the resident fell, complained of pain and was sent to the hospital where she was diagnosed with multiple rib fractures. Upon return to the facility the resident was in a lot of pain and administered pain medication as ordered. The resident's wounds were assessed by a physician the following week. The nurse also assessed the resident and updated the resident's care plan to include pressure-relieving interventions to assist in wound healing. The nurse stated the resident's left heel area has since resolved and the right heel is slowly healing.

In conclusion, the Minnesota Department of Health determined 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.
Insert maltreatment definition here.

Vulnerable Adult interviewed: No, resident declined.
Family/Responsible Party interviewed: No.
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
After the resident fell staff reported, assessed and the resident was transported to the hospital. The resident’s wounds were assessed by a physician and a wound care agency was involved in the management of the resident’s wounds in coordination with facility staff.

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
	25729	A. BUILDING: _____ B. WING _____	C 07/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SELECT SR LVG COON RAPIDS LLC	11350 MARTIN STREET 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 On July 29th, 2026, the Minnesota Department of Health initiated an investigation of complaint #HL257293468M/ HL257292858C. No correction orders are issued.	0 000		