Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL340794086M
Compliance #: HL340794141C

Date Concluded: October 26, 2026

Name, Address, and County of Licensee Investigated:
Elk River Senior Living
11124 183rd Circle NW 136
Elk River, MN 55330
Sherburne County

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

Evaluator's Name:
Katherine Barnhardt RN, 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 alleged perpetrator (AP), a facility staff, neglected the resident when the resident fell, sustained broken ribs and medical care was delayed.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. It was determined the AP was not responsible for neglect; however, the facility was found responsible for neglect. The facility failed to assess the resident after the resident's fall and three days later the resident was hospitalized with three fractured ribs.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted a hospice and triage agency. The investigation included review of the resident records, death record, hospital records, pharmacy records, facility internal investigation, facility incident reports, personnel files, staff schedules,

and related facility policy and procedures. Also, the investigator observed unlicensed staff provide direct cares.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia. The resident's service plan included assistance with escorts to and from the dining room for meals, however, independent with ambulation and transfers. The resident's assessment indicated the resident was a fall risk and had a history of falls but did not use assistive devices for ambulation.

An internal investigation record indicated the AP phoned and reported to triage that the resident was agitated, anxious and was pushing chairs. The resident had fallen backwards, onto her bottom and had pain in her side. The AP was instructed to give an anti-psychotic medication and to call triage back if vital signs were outside of normal range. The AP reported to triage that vital signs were within normal range.

A hospice incident report indicated the facility's triage notified the hospice agency and reported the resident was observed intentionally sitting down on the dining room floor. The resident got herself up independently and there were no concerns with the resident's mobility. A visit from the hospice nurse was declined by the facility's licensed staff.

Video footage reviewed indicated the AP was on the opposite side of the dining room when a second unlicensed staff member was engaged with the resident. At 16 seconds into the video footage, the resident and a second unlicensed staff member struggle over what appeared to be dining utensils. Approximately four seconds later, the resident stepped back, lost her balance and fell backwards. The resident struck her right side on the arm of a chair and then struck her left rib area on the arm of a different chair. The second unlicensed staff member continued to arrange items on the table while the resident was on the floor next to the dining table. The video footage revealed the AP approached the resident, engaged with the resident for a few seconds and then turned and walked away from the resident. Throughout the video, several facility staff were observed walking around the dining room and did not engage with or assist the resident off the floor. Approximately 15 minutes after the resident fell, the resident got herself off the floor and into a chair.

A triage transcript record indicated the AP phoned triage and reported the resident's fall. A language barrier occurred and triage staff attempted to clarify throughout the call the resident's pain status. The AP reported the resident was having pain and the triage transcript verified a pain was reported.

A progress note written two days after the fall by facility licensed staff indicated unlicensed staff observed the resident pushing a chair out of the way and purposefully sit down on the dining room floor. The progress note indicated unlicensed staff administered an as needed anti-psychotic for pacing and agitation. The progress note indicated a provider was notified.

A progress note written three days after the fall by facility licensed staff indicated the resident had increased anxiety, congestion, wheezing and low oxygenation. The resident was unable to follow instructions to take a deep breath. Hospice staff, a provider, and a family member were notified. Family requested the resident be sent to an emergency room for evaluation and the resident was transported by ambulance to an emergency room. Emergency personnel noted bruising along the resident's left rib area. The resident was transferred from the emergency room to a trauma center and admitted with three fractured ribs on the left side and pneumothorax (air leaks between lung and chest wall causing lung to collapse) monitoring.

Hospital records indicated the resident was admitted to the hospital with three fractured ribs. The resident was hospitalized for two nights, stabilized and discharged back to the facility with hospice services.

The facility failed to assess and implement new interventions after the resident fell. The resident had increased anxiety, agitation and low oxygen saturation levels prior to being transported to the hospital.

During an interview, an unlicensed staff stated her coworker, the AP, called triage and when the AP was on the phone with triage, she told the AP to report the resident had left side pain. The AP verbalized triage was told about pain in the resident's left side. An unlicensed staff stated triage may have misunderstood the word "side" for "thigh" due to language differences; however, side pain was written on the incident report given to facility licensed staff.

During an interview, the AP stated she was doing a task in the dining room, when the resident fell. Triage was notified and the fall was reported. The AP stated the resident was sitting on the floor, shaking, agitated and was holding her side. As needed medication was provided to the resident. The AP stated an incident report was completed and placed under the nursing office door for review when the facility licensed staff returned.

During an interview, a facility licensed staff stated it was possible the AP and a second unlicensed staff had not seen the resident fall because they were tending to other residents in the dining room. The resident was independent with walking and moved about frequently. The resident was observed on the floor by the AP who took vital signs and called triage for direction. Licensed staff stated the AP had a thick accent and triage may have misunderstood the word "thigh" for "side" when the fall was reported, however, the AP followed triage direction which was protocol. The facility licensed staff stated no assessment was completed on the resident following the resident's fall.

During an interview, a family member stated there was some sort of altercation between the resident and an unlicensed staff, the resident was agitated, unlicensed staff were in front of her and the unlicensed staff wouldn't allow the resident to move forward. The resident backed up and fell backwards hitting a chair and a couch. A family member stated the resident got up on her own and an assessment had not been done. Three days later, a family member was updated

the resident had low oxygen, was breathing heavily and the resident was sent to the emergency room where the resident yelled out in pain and was diagnosed with three fractured ribs.

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: Deceased
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The facility conducted an internal investigation.

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
Sherburne County Attorney

Elk River City Attorney
Elk River Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34079	A. BUILDING: _____ B. WING _____	C 10/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELK RIVER SENIOR LIVING	11124 183RD CIRCLE NW ELK RIVER, MN 55330

(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: #HL340794086M/#HL340794141C On October 12, 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 49 residents receiving services under the provider ' s Assisted Living with Dementia Care license. The following correction order is issued for	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	

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0 000	Continued From page 1 #HL340794086M/#HL340794141C, tag identification 2360.	0 000	ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
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(s) reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and 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		