Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL257292242M
Compliance #: HL257293711C

Date Concluded: July 31, 2025

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

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

Evaluator's Name: Brooke Anderson, 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 facility neglected the resident when the resident was sent to the hospital in soiled clothes and was found with pressure injuries on his coccyx (tailbone).

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although the resident had a wound on his coccyx when he was sent to the hospital after a fall, there was not a preponderance of evidence that neglect occurred. The resident was assessed by a facility nurse one day before the incident. Facility staff provided care based on the resident's plan of care and preferences.

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

related facility policy and procedures. Also, the investigator observed interactions between staff and residents.

The resident resided in an assisted living facility. The resident's diagnoses included type 2 diabetes and hypertension. The resident's service plan included assistance with showers and meal delivery. The assessment indicated the resident was cognitively intact.

A progress note indicated a facility nurse assessed the resident after he reported complaints of congestion. Vitals signs were stable, and lung sounds were clear, and the nurse documented a mild cough. However, a family member who was present during the assessment reported the resident had a mild cough at baseline. The resident denied feeling sick and the nurse advised the resident and family to report to staff any additional concerns.

The next day the resident was found on the ground tangled in his recliner. The resident was incontinent and was unable to speak to staff or bear weight. 911 was notified and the resident was sent to the hospital.

Hospital records indicated when emergency medical services arrived, the resident was incontinent of urine. The resident was found to have a wound on his coccyx. The family had no concerns with the care at the facility. The resident was diagnosed with pneumonia and was discharged to a higher level of care.

During an interview, a staff member stated the resident was independent and when his wife passed, he started to decline. Facility nurses were updated and assessed the resident with recent concerns. A staff member reported the resident had a history of refusing services including toileting and showers and reapproaching the resident at a later time was attempted but not always effective. A staff member was not aware of any wounds on the resident.

During an interview, facility nurse #1 stated the resident received showers from facility staff but often refused them and reported he showered independently. Facility nurse #1 stated there were no concerns with hygiene noted prior to his wife's passing and the resident was continent of bowel and bladder. Facility nurse #1 was not aware of any wounds on the resident.

During an interview, facility nurse #2 stated prior to the resident's wife passing, the resident was relatively independent. There were concerns that the resident would need additional services during the time of transition, however he was hospitalized within days after his wife's passing.

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.

Vulnerable Adult interviewed: No, resident had since passed.
Family/Responsible Party interviewed: No, attempts made were not successful.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
A facility nurse assessed the resident a day prior to the incident. When the resident fell, facility staff called 911 and he was sent to the emergency room.

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 07/09/2025

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 9, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL257293711C/#HL257292242M. No correction orders are issued.	0 000		