

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL306892502M
Compliance #: HL306894409C

Date Concluded: July 22, 2025

Name, Address, and County of Licensee

Investigated:

Boden Senior Living
11372 Robinson Drive
Coon Rapids, MN 55433
Anoka County

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

Evaluator's Name: Lissa Lin, 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. The resident had chronic leg wounds that were wrapped and required wound care and management. She developed lower limb ischemia (no circulation) with gangrene and was hospitalized. The resident died from sepsis.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined neglect was not substantiated. The resident was her own decision maker. She had weekly out-patient complex wound care visits and treatments for chronic leg ulcers and osteomyelitis. The facility did not manage her wounds; therefore the nurse did not assess the resident's legs because they were wrapped with compression dressings and in soft casts. The resident did not often share information from the clinic visits with the facility nurse. When the resident experienced a change in condition a few days after a wound clinic visit, the nurse called 911 and sent the resident to the hospital. The resident was admitted and died from critical limb ischemia and gangrene.

The investigator conducted interviews with facility staff members, including nursing staff, and unlicensed staff. The wound physician was not available for an interview. The investigation included review of the resident records, her death record, hospital records, wound clinic records, facility incident reports, staff schedules, and related facility policy and procedures

The resident resided in an assisted living facility. She had a complex medical history. Her diagnoses included osteomyelitis (bone infection that causes inflammation and destruction of bone tissue) of the left foot, bilateral foot ulcers, peripheral edema (swelling of legs and feet), paraplegia from a motor vehicle accident, and prediabetes.

The resident's service plan included assistance with medication administration, safety checks, toileting and full mechanical transfers. She used an electric scooter for mobility. The resident's assessment indicated she had complex wound dressings in place with ortho boots and went to wound clinic weekly. She had some memory impairment and needed help taking medications but was cognitively intact.

Wound care records indicated the resident had chronic leg and foot ulcers. The right leg and foot wounds had signs of infection but there no systemic infection. Some wounds were down to the fatty layer beneath the skin with some necrotic (dead) tissue. Her leg swelling was under good control. Her wounds were cleaned and redressed. She was prescribed a second antibiotic and planned to return to the clinic next week.

Progress notes indicated the resident returned to the facility from her clinic visit and reported to the nurse that the podiatry-wound doctor had performed wound cares on her legs and buttock, applied barrier cream and prescribed a new antibiotic. The nurse contacted the wound care clinic to clarify that the resident needed to take two antibiotics together. During the call, the wound clinic staff told the nurse they did not care for any wounds above the knee. The nurse then contacted the resident's primary physician for wound care and home care orders for the right-side buttock wound, which the nurse assessed as reddened with an open area but without infection. Staff applied barrier cream daily to her buttock during morning toileting.

About three days later, staff members informed the nurse the resident appeared confused. The nurse assessed the resident, who said "um, um" repeatedly and could not answer questions. Her vital signs were low. The nurse called 911 and the resident went to the hospital. She was admitted and died approximately 24 hours later.

Hospital records indicated she admitted with acute shock, acute kidney injury, ischemic legs and rhabdomyolysis, (a serious condition where damaged muscle cells breakdown and release toxins into bloodstream).

During an interview, the nurse said the resident was very private, made her own decisions and did not have much family involvement. The nurse said the resident had chronic leg wounds for years. The facility did not offer complex wound cares, which was what the resident required, so

she used out-patient services. The resident made it clear that only wound clinic staff handled her leg dressings, so it was unlikely any staff members ever removed or re-wrapped the resident's leg dressings. The nurse said she helped a staff member get the resident ready for bed on a Friday night, a few days after her clinic visit. Her legs looked normally wrapped. There was no smell or drainage to indicate gangrene. The following Monday morning the resident refused to get out of bed and was confused. The nurse said she was not comfortable keeping the resident and called 911. Later, when she called the hospital for an update, she learned the resident was septic, in kidney failure and dying. The nurse contacted the resident's family member and instructed her to call the hospital. The resident's cause of death was critical limb ischemia of both lower legs with gangrene.

The podiatry-wound doctor was not available for an interview.

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, deceased.

Family/Responsible Party interviewed: No, resident made her own decisions.

Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:

The facility nurse assessed the resident and sent her to the hospital.

Action taken by the Minnesota Department of Health:

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30689	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/17/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER BODEN SENIOR LIVING - COON RAPIDS	STREET ADDRESS, CITY, STATE, ZIP CODE 11372 ROBINSON DRIVE 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	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>ASSISTED LIVING PROVIDER CORRECTION ORDER</p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation.</p> <p>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.</p> <p>INITIAL COMMENTS:</p> <p>HL30689447C/HL306892542M HL30894409C/HL306892502M</p> <p>On June 17, 2025 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 45 residents receiving services under the provider's Assisted Living with Dementia Care license.</p> <p>The following correction order is issued for HL306894409C/HL306892502M, tag identification 0730.</p> <p>The following correction order is issued for HL30689447C/HL306892542M, tag 2360.</p>	0 000	<p>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.</p> <p>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.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p> <p>THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.</p>	
0 730 SS=D	<p>144G.43 Subd. 3 Contents of resident record</p> <p>Contents of a resident record include the</p>	0 730		

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30689	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/17/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER BODEN SENIOR LIVING - COON RAPIDS	STREET ADDRESS, CITY, STATE, ZIP CODE 11372 ROBINSON DRIVE 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
0 730	<p>Continued From page 1</p> <p>following for each resident:</p> <p>(1) identifying information, including the resident's name, date of birth, address, and telephone number;</p> <p>(2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative;</p> <p>(3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known;</p> <p>(4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records;</p> <p>(5) the resident's advance directives, if any;</p> <p>(6) copies of any health care directives, guardianships, powers of attorney, or conservatorships;</p> <p>(7) the facility's current and previous assessments and service plans;</p> <p>(8) all records of communications pertinent to the resident's services;</p> <p>(9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional;</p> <p>(10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional;</p> <p>(11) documentation that services have been provided as identified in the service plan;</p> <p>(12) documentation that the resident has received and reviewed the assisted living bill of rights;</p> <p>(13) documentation of complaints received and any resolution;</p>	0 730		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30689	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/17/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER BODEN SENIOR LIVING - COON RAPIDS	STREET ADDRESS, CITY, STATE, ZIP CODE 11372 ROBINSON DRIVE 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
0 730	<p>Continued From page 2</p> <p>(14) a discharge summary, including service termination notice and related documentation, when applicable; and</p> <p>(15) other documentation required under this chapter and relevant to the resident's services or status.</p> <p>This MN Requirement is not met as evidenced by: Based on record review and interviews, the licensee failed to ensure the contents of a resident record included contact information for medical providers and documentation of significant changes in the resident's status and actions taken for one of two residents (R2) reviewed. R2's record lacked documentation that nursing staff attempted to contact the wound care provider for regular updates on R2's leg wounds and complex wound dressings. R2 was hospitalized with sepsis and died.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).</p> <p>The findings include:</p> <p>R2's facesheet lacked contact information or the name of R2's wound care medical provider.</p> <p>R2's medical diagnoses include paraplegia, cellulitis of left lower limb and chronic kidney disease. R2 used an electric wheelchair.</p>	0 730		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30689	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/17/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER BODEN SENIOR LIVING - COON RAPIDS	STREET ADDRESS, CITY, STATE, ZIP CODE 11372 ROBINSON DRIVE 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
0 730	<p>Continued From page 3</p> <p>R2's nursing assessment dated April 21, 2025, indicated in the Skin Integrity section she had an open area wound and in the description section: "unable to assess as complex wound dressing in place with ortho boot, resident gets wound care weekly at clinic."</p> <p>R2's service agreement dated April 23, 2025, indicated R2 received staff assistance of two for mechanical lift transfers, toileting and dressing assistance and safety checks. R2 was assessed by the nurse as able to make her needs known and make her own decisions.</p> <p>A progress note by director of health services (DHS)-A dated April 23, 2025, at 4:44 p.m., indicated R2 returned from wound clinic, did not provide any paperwork from visit but reported the doctor did wound cares to her legs and buttocks. New antibiotic, clindamycin 300 milligrams by mouth twice a day for 14 days started.</p> <p>A progress note by DHS-A dated April 24, 2025, at 1:11 p.m., indicated a call was placed to R2's foot care doctor office to clarify antibiotic orders. R2 had two antibiotics, levaquin and clindamyin. Staff from the foot care office reported the doctor did not address wounds above the knees.</p> <p>A progress note by DHS-A dated April 25, 2025, at 1:16 p.m., indicated DHS-A called R2's PCP to provide an update to buttocks wounds, requested home care and wound care services until buttock wounds healed.</p> <p>A progress note by DHS-A dated April 28, 2025 at 10:42 a.m., indicated R2 appeared confused and had low blood pressure and low oxygen saturation rate. Emergency medical services was called and took R2 to the hospital. A progress</p>	0 730		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30689	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/17/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER BODEN SENIOR LIVING - COON RAPIDS	STREET ADDRESS, CITY, STATE, ZIP CODE 11372 ROBINSON DRIVE 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
0 730	<p>Continued From page 4</p> <p>note dated April 28, 2025, at 4:10 p.m., indicated R2 was in kidney failure.</p> <p>A progress note by DHS-A dated April 29, 2025 at 5:47 p.m. indicated R2 died at the hospital. R2's leg wound was managed by an outside provider routinely every week was not getting good blood flow. R2's antibiotics were not getting to the site of infection, causing sepsis per the hospital, and this caused R2's kidneys to fail.</p> <p>During an interview on June 17, 2025, at 9:20 a.m., DHS-A said R2 was very independent and had few services. She had her leg wounds and treatments long before she admitted to the licensee. R2 did not tell staff when she went to see providers and did not give them paperwork after visits. R2 had both legs wrapped and would not let nursing staff assess them.</p> <p>During an interview on June 25, 2025, at 10:01 a.m., DHS-A said she verified that R2 went to a wound clinic with R2's family member and the clinic. DHS-A said R2 told staff only the wound doctor could unwrap and redress her leg wounds. DHS-A said she saw one of R2's leg wounds once over one year ago and it was down to the bone.</p> <p>A Change in Condition Guideline, revised May, 2024, indicated a change in condition can include the presence of a wound requiring treatment and monitoring. Daily monitoring; RN to assess changes and document in resident record.</p> <p>TIME PERIOD TO CORRECT: Twenty-one (21) Days</p>	0 730		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30689	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/17/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER BODEN SENIOR LIVING - COON RAPIDS	STREET ADDRESS, CITY, STATE, ZIP CODE 11372 ROBINSON DRIVE 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
02360	Continued From page 5	02360		
02360	<p>144G.91 Subd. 8 Freedom from maltreatment</p> <p>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.</p> <p>This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident reviewed (R1) was free from maltreatment.</p> <p>Findings include:</p> <p>The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual person was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.</p>	02360		