Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Project: HL306896622M
Compliance Project: HL306895845C

Date Concluded: December 24, 2025

Name, Address, and County of Licensee Investigated:
Boden Senior Living Coon Rapids
11372 Robinson Dr NW
Coon Rapids, MN 55433
Anoka County

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

Evaluator's Name: Deb Schillinger RN BSN
Special Investigator

Finding: Inconclusive

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) abused the resident when he was helping her to bed in a manner that pinched her arm leaving a bruise. In addition, the AP shut all the lights off in the room when the resident requested the bathroom light be left on.

Investigative Findings and Conclusion: The Minnesota Department of Health determined abuse was inconclusive. The AP denied being rough with the resident or pinching the resident. The AP also denied ignoring the request to leave the resident's bathroom light on.

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

The resident resided in a secured assisted living facility. The resident's diagnoses included Parkinson's disease and frequent falls. The resident's service plan included assistance with dressing, reminders and assist with interventions to prevent falls. The resident's assessment indicated she had cognitive impairment, ambulated with a walker and had frequent falls.

A concern arose when the resident reported to the nurse manager the AP was mean to her, grabbed her arm and told her to go to sleep.

The resident's medical record indicated the nurse manager identified a bruise on the resident's left arm.

The facility internal investigation report indicated the resident reported the AP pinched her right arm, however the same report indicated the nurse found bruising on the residents left arm.

The resident's medical record included four falls in the previous week, two of which indicated the resident had fallen on her right side.

The resident's family member stated she was not present during the incident and was unsure if the resident's bruise on the resident's right arm was from a pinch as it could have been a result from one of several falls which occurred around the same time.

During an interview, the AP denied pinching the resident's arm or ignoring her requests to leave the bathroom light on. The AP stated all cares were provided with ULP #2 present.

During an interview, ULP #2 stated she was with the AP when cares were provided to the resident. ULP #2 stated the AP did pinch the resident nor ignore a request to leave the bathroom light on.

In conclusion, the Minnesota Department of Health determined abuse was inconclusive.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or did not occur.

Abuse: Minnesota Statutes section 626.5572, subdivision 2.
"Abuse" means
(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:
(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;

(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening.

Vulnerable Adult interviewed: No, due to cognitive impairment
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility: The facility suspended the AP and investigated. The facility no longer employed the AP. The facility provided reeducation to all staff on abuse prevention and customer service.

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
Department of Human Services (DHS) Background Study Unit

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30689	A. BUILDING: _____ B. WING _____	C 11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BODEN SENIOR LIVING - COON RAPIDS	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	Initial Comments On November 19, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL306895845C/#HL306896622M. No correction orders are issued.	0 000		