Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL340791600M
Compliance #: HL340796302C

Date Concluded: May 21, 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: Ann Boutwell, 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):
A facility staff member neglected the resident when the facility did not provide a toileting service resulting in a fall with a fracture.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although the resident had a fall resulting in a shoulder fracture, there was not a preponderance of evidence that the fall was caused by the failure of facility staff to provide necessary care or services. The resident was assessed, and pain was treated in collaboration with the hospice team.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the hospice agency. The investigation included review of the resident records, internal facility investigation, facility incident reports, personnel files, staff schedules, hospice records and related facility policy and

procedure. Additionally, the investigator observed facility staff provide direct care to residents of the facility.

The resident resided in an assisted living memory care unit. The resident's diagnoses included anxiety and dementia. The resident's services included assistance with cues, transfers, toileting, feeding and ambulation. The resident was assisted with a manual wheelchair and a Broda chair (a tilt in space positioning wheelchair). The resident's assessment indicated increased confusion, weakness, weight loss, and vision deficits. The resident received hospice services, had a history of falls and attempted self-transfers. The resident had a history of declining toileting assistance and would become agitated when staff offered.

An internal investigation indicated a hospice staff assisted the resident out of the dining room at 12:23 p.m. for massage therapy and returned the resident to the dining room at 12:45 p.m. The resident was scheduled for a 1:00 p.m. toileting. At 1:15 p.m. the facility staff assisted the resident back to her room in her Broda chair and at 1:17 p.m. the facility exited the resident's room. Camera footage reviewed by licensed staff during the internal investigation showed a medical provider entered the resident's room at 1:46 p.m. The internal investigation indicated that another facility staff found the resident on the floor in her room at 4:15 p.m. The internal investigation did not determine a specific cause for the resident's fall.

During an interview, facility staff stated she was assigned to provide cares for the resident on the day the resident fell. After lunch she assisted the resident back to her room and offered toileting assistance. When she asked the resident about toileting and she said no, the facility staff accepted that answer. Facility staff left the resident in her room sitting in her Broda chair for a nap at the resident's request. Facility staff stated the resident was always tired and the facility staff had never observed the resident attempt to stand up from the Broda chair.

During an interview, licensed staff stated the resident had a history of refusing cares, had falls, attempted to self-transfer and interventions for fall prevention were in place. Licensed staff stated a facility staff brought the resident to her room after lunch and after reviewing the camera footage the facility staff did not complete the toileting service. The licensed staff stated the after the facility staff brought the resident to her room the medical provider conducted a routine visit and had no concerns, and the resident was not on the floor at that time. The resident was found on the ground when a facility staff went to complete the resident's 4:00 p.m. toileting.

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, attempted.
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The facility added safety checks in between scheduled toileting.

Action taken by the Minnesota Department of Health:
No further action is 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
	34079	A. BUILDING: _____ B. WING _____	C 04/08/2026

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 On April 8, 2026, the Minnesota Department of Health initiated an investigation of complaints HL340791600M/HL340796302C. No correction orders are issued.	0 000		