

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** HL340795062M  
**Compliance #:** HL340791423C

**Date Concluded:** October 17, 2025

## **Name, Address, and County of Licensee**

### **Investigated:**

Elk River Senior Living  
11124 183<sup>rd</sup> Circle Northwest  
Elk River, MN, 55330  
Sherburne County

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

**Evaluator's Name:** Angela Vatalaro, 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 alleged perpetrator (AP) abused a resident when the AP attempted to force medications into the resident's mouth.

### **Investigative Findings and Conclusion:**

The Minnesota Department of Health determined abuse was not substantiated. Although the AP's actions were unprofessional and not therapeutic, the AP did not force the medications into the resident's mouth. Unlicensed personnel (ULP) witnessed the AP place her left hand on the resident's chin with her thumb on one side of his cheek and fingers on the other cheek. During the AP's action, the resident was able to and continued to move his head from side to side to avoid the spoon. The spoon did not enter the resident's mouth. There was no visible facial skin marks observed. The facility retrained staff on conduct with residents.

The investigator conducted interviews with facility staff members, including nursing staff, and unlicensed staff. The AP declined to interview. The investigation included review of the resident

records, facility internal investigation, facility incident reports, a personnel file, and related facility policy and procedures. Also, the investigator observed the resident and staff interactions with the resident.

The resident resided in an assisted living memory care unit. The resident's diagnoses included Alzheimer's disease. The resident's service plan included assistance with medication administration. The resident's assessment indicated the resident was disoriented, had aphasia (loss of the ability to produce or comprehend language,) and took medications crushed in soft food.

The facility's internal investigation indicated a ULP witness stated the resident had moved his head side to side and pressed his lips together during medication administration. The AP held the resident's chin and tried to force medication into the resident's mouth. The ULP indicated in a written statement the resident was refusing his medications and moved his face side to side. The ULP stated the AP grabbed the resident's face and forced medication into his mouth.

The facility's internal investigation indicated the AP denied grabbing the resident's face or attempt to force medication into his mouth. The AP said she touched the resident's cheek to see if he would take the medication.

During an interview, the ULP stated herself and the AP were both in the resident's room. The AP was administering medication, the ULP was in the room at the same time to empty the resident's catheter bag. The resident was nonverbal. The resident was awake and seated in a chair. The resident's medication was crushed in soft food and on a spoon. The ULP stated herself and the AP told the resident prior to administration, they were going to give him his medication. When the AP brought the spoon up to the resident's mouth, the resident moved his head side to side, his mouth was closed. During the second attempt, the ULP said she tried to administer the spoonful of medication but still refused. The ULP said the resident was not shaking his head as if saying no, he moved his head to avoid and dodge the spoon when brought up to his mouth. The AP attempted again. During the third attempt the AP brought the spoon up to the resident's mouth, the resident continued to move his head from side to side with his mouth closed. The ULP said at that point, the AP "grabbed" the resident's face to hold his head still. When asked what she meant by grab, the ULP said the AP's left hand was on the resident's chin with her thumb on one side of his cheek and her fingers on the other cheek. The ULP stated the resident continued to move his head from side to side during the AP's actions and there was no physical skin marks observed after the incident. The ULP stated the spoon did not enter the resident's mouth nor was the medication administered. The resident did not take his medication. When asked what the resident did after these medication administration attempts, the ULP stated the resident appeared "fine" and said nothing abnormal was observed. Both staff members left the resident's room.

The resident's medication administration record indicated the resident did not receive the medication the day and time in question.

During an interview, nurse 1 stated the resident was nonverbal. Nurse 1 said the resident's dementia was advanced, participation in medication administration varied, and had been challenging for staff. The resident had an order to crush medication and put in soft food. The facility used food items such as pudding or yogurt. The facility used various techniques to encourage compliance. Techniques included unlicensed staff attempting administration three times, to come back later, or a different staff member trying. The nurse said the resident took medications sometimes at other times he did not. Nurse 1 said when she seen the resident, the resident did not have any visible marks on his face. Nurse 1 also said the resident did not display any body language of fear or act in a way where he did not want anyone to approach him. Nurse 1 said there had been no similar allegations against the AP involving attempts to force residents to take medications. Nurse 1 also said there were no cameras in the resident's room.

During an interview, nurse 2 stated she had seen the AP interact with the resident and other residents. Nurse 2 said she had not seen or heard of any resident appearing fearful or scared around the AP. Nurse 2 said the resident had since admitted to hospice services, most of the resident's crushable medications had since discontinued, and there was a medication administered in liquid form.

The AP declined to interview.

In conclusion, the Minnesota Department of Health determined abuse 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.

**Abuse: Minnesota Statutes section 626.5572, subdivision 2.**

"Abuse" means:

- (a) An act against a vulnerable adult that constitutes a violation of, an attempt to violate, or aiding and abetting a violation of:
- (1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224;
  - (2) the use of drugs to injure or facilitate crime as defined in section 609.235;
  - (3) the solicitation, inducement, and promotion of prostitution as defined in section 609.322;
- and
- (4) criminal sexual conduct in the first through fifth degrees as defined in sections 609.342 to 609.3451.

A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.

- (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; or

(3) use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion, including the forced separation of the vulnerable adult from other persons against the will of the vulnerable adult or the legal representative of the vulnerable adult unless authorized under applicable licensing requirements or Minnesota Rules, chapter 9544.

(c) Any sexual contact or penetration as defined in section [609.341](#), between a facility staff person or a person providing services in the facility and a resident, patient, or client of that facility.

(d) The act of forcing, compelling, coercing, or enticing a vulnerable adult against the vulnerable adult's will to perform services for the advantage of another.

**Vulnerable Adult interviewed:** Yes.

**Family/Responsible Party interviewed:** Yes.

**Alleged Perpetrator interviewed:** No. Declined an interview.

**Action taken by facility:**

The facility conducted an internal investigation, provided staff reeducation on the facility's code of conduct and vulnerable adult reporting. The AP is no longer employed by the facility.

**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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>34079</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/26/2025</b>
--	--	---	---

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

(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><b>Initial Comments</b></p> <p>On August 26, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL340791423C/#HL340795062M. No correction orders are issued.</p>	0 000		
-------	--	-------	--	--

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