Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL349941841M
Compliance #: HL349946866C

Date Concluded: July 1, 2026

Name, Address, and County of Licensee Investigated:
Creekside Villas Assisted Living
1177 117th Avenue Northwest
Coon Rapids, MN, 55448
Anoka County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Kris Detsch, RN
Special Investigator

Finding: Substantiated, facility responsibility

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 they failed to provide bathing and dressing. As a result, they failed to recognize the resident had a bandage on his arm and did not remove it. This caused a life threatening skin infection (sepsis).

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The bandage on the resident's arm was from a blood draw he had at the facility 20 days prior to his hospitalization. During this time, resident records indicated staff assisted him with dressing, undressing, and bathing. Staff reported they did not complete these services but documented they completed the services in the resident's clinical record. The bandage had imbedded into the resident's skin and the duration caused a severe skin infection requiring hospitalization and intravenous antibiotics.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted a case worker. The investigation included review of the resident records, death record, hospital records, facility internal investigation, facility incident reports, personnel files, staff schedules, law enforcement report, related facility policy and procedures Also, the investigator toured the facility and observed medication administration, staffing structure, and documentations systems.

The resident resided in an assisted living facility. The resident's diagnoses included brain cancer, memory loss, communication deficit, seizure disorder, and heart disease. The resident's service plan included assistance with bathing, dressing, grooming, incontinence care, medications, and behavior management. The resident's nursing assessment indicated he required staff to provide "full assistance" with bathing and showering. The resident required staff to remind him to change his clothes because he did not change his clothing daily. The resident had memory loss and limited ability to communicate his needs.

Physician visit records indicated the resident received a blood draw at the facility 20 days prior to his hospitalization.

Service delivery records indicated a staff member documented they completed bathing assistance five days before the resident went to the hospital. Another staff member documented she completed bathing assistance the day before the resident went to the hospital. Service delivery records indicated staff members consistently documented they provided grooming and dressing assistance twice daily.

Resident records indicated the resident's health status was declining around the time of this incident; however, the facility failed to review/update the services they provided to ensure they met his daily care needs.

An incident report indicated the resident fell late in the night. A staff member responded and found him on the face down on the floor, but he was able to get himself up back to his bed. The report indicated, the staff member called emergency services (911) to take the resident to the hospital.

Hospital records indicated the resident appeared unkempt, disheveled, and poorly taken care of. Hospital staff discovered the resident had a Coban wrap (bandage) around his left upper arm, just above his elbow. The physician determined the bandage had been there for a long period of time because the bandage eroded (destroyed) the resident's skin. The resident had cellulitis (infection of his skin). Further diagnostic testing indicated the resident also had pneumonia (lung infection). The resident had sepsis (life threatening infection) and required multiple intravenous (IV) antibiotic medications. The resident remained in the hospital for four days and returned to the facility.

During an interview, a nurse manager said she completed an internal investigation after the resident returned to the facility. The manager said she reviewed the staffs documentation, physician records, hospital records, and she interviewed staff members. The manager said she could not determine when the resident received the bandage to his arm. The facility used a lab company who sent technicians to the facility to complete blood draws. The manager said she presumed the lab technician placed the bandage to the resident's arm after they drew his blood, and the facility staff were not aware the bandage was there. The manager said staff members told her the resident refused bathing and grooming cares, but they documented these tasks as "completed" because they did not know how to document his refusal. The manager said the staff's documentation was inaccurate and the facility provided re-education to their staff members. The facility told the lab company not to use Coban bandages after blood draws, but only apply a cotton ball and a band-aid. The manager said the facility felt a cotton ball and band-aid was safer. The manager acknowledged staff would have to remove this type of bandage also.

During an interview, a nurse said the resident's health declined a few days before he went into the hospital and he stayed in bed most of the time. The nurse said the resident's appetite was poor, so the physician told staff to give the resident protein shakes. The nurse said he assessed the resident's skin when he returned to the facility after the hospital and said the skin around the resident's left inner arm (antecubital area) had some "scabs," but the skin was not red or bleeding.

During investigative interviews, multiple staff members said the resident required assistance with bathing and dressing. The resident could not perform these tasks independently. Staff members indicated the resident was not always accepting of assistance and they could not "force" him to have these tasks completed.

In conclusion, the Minnesota Department of Health determined neglect was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

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: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility provided re-education to their staff members on documentation.

Action taken by the Minnesota Department of Health:
The responsible party will be notified of their right to appeal the maltreatment finding.

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
Anoka County Attorney
Coon Rapids City Attorney
Coon Rapids Police Department
Minnesota Board of Executives for Long Term Services and Supports

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34994	A. BUILDING: _____ B. WING _____	C 06/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREEKSIDE VILLAS ASSISTED LIVING	1177 117TH AVENUE COON RAPIDS, MN 55448

(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 ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. 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. INITIAL COMMENTS: HL349946866C/HL349941841M On June 3, 2026, 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 five residents receiving services under the provider's Assisted Living license. The following correction orders are issued for HL349946866C/HL349941841M, tag identification 1640 and 2360.	0 000	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. 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. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. 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.	
01640 SS=J	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to	01640		

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01640	Continued From page 1 (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record reviewed, the licensee failed to implement bathing and grooming services as indicated on service plans for three of three residents (R1, R2, and R3) with record reviewed. As a result of this deficient practice, a Coban wrap (bandage) remained on R1's arm for twenty days and he developed a skin infection. R1 required hospitalization and intravenous (IV) antibiotic medications. The facility failed to implement nail care for R2 and R3, which did not result in harm. This practice resulted in a level four violation (a violation that harmed a resident ' s health or safety, not including serious injury or death, or a	01640		

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01640	Continued From page 2 violation that was likely to lead to serious injury 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). The findings include: R1 R1 admitted to the licensee for diagnoses including brain cancer, seizures, and cognitive impairment. R1's service plan dated August 7, 2025, included assistance for the following: -Bathing assistance two days a week -Dressing assistance two days a week, in the morning -Dressing assistance, in the evening, daily -Grooming assistance two times a day, daily -Incontinence care four times per day, daily R1's 90-day nursing assessment dated January 27, 2026, indicated he required "full assistance" with bathing/showering. R1 required assistance washing all areas of his body. Staff were to assist him with washing his hair, back and other areas as needed. The assessment indicated the licensee required their staff to lay out his clean clothes and prompt him to put on new clothes on the days he showered, or as needed if soiled. R1 would not change clothing daily and slept in his clothing. The assessment indicated R1 had intellectual disability and impaired judgement. R1 had a "cognitive communication deficit". Physician visit notes dated January 23, 2026, indicated R1's nurse practitioner (NP) evaluated R1 at the licensee's building. The NP ordered the	01640		

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01640	Continued From page 3 licensee to obtain lab work (blood draw) on January 26, 2026. Physician visit records dated February 13, 2026, included lab values (results) from the blood draw on January 26, 2026. Hospital records dated February 15, 2026, indicated the licensee sent R1 to the hospital because he fell. Hospital records indicated R1 appeared unkempt, disheveled, and poorly taken care of. Hospital staff found a Coban tourniquet (bandage) attached to R1's distal left arm. They removed the bandage and found a four centimeter laceration (cut), with surrounding erythema (red/inflamed) and induration (hard skin). Hospital records indicated the bandage had been there for a long time. R1 had a fever, and physicians required multiple diagnostic testing to determine the source. R1's hospital diagnoses included sepsis (life threatening infection) and cellulitis (skin infection). R1 also had pneumonia which contributed to his illness. R1 required multiple intravenous (IV) antibiotic medications. Facility Internal review (investigation) dated February 19, 2026, indicated the licensee reviewed hospital documentation regarding the bandage on R1's arm. The internal review indicated multiple staff members told the licensee's management, they documented they completed bathing services, but R1 refused so they did not complete his bathing/grooming services. Multiple staff indicated they did not know how to document his refusal. The internal review indicated the licensee provided re-education to their staff. The licensee contacted the blood draw agency and told them to have their technicians only place a cotton ball and band-aid to resident's skin after blood draws.	01640		

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01640	Continued From page 4 Service delivered record dated February 1, 2026, through February 20, 2026, indicated the licensee staff falsely documented (per investigation reported he refused) bathing services after the resident's blood draw on January 26, 2026. Bathing/Showering documented as follows: -February 7, 2026, at 8:28 a.m., thirty minutes -February 10, 2026, at 12:27 p.m., thirty minutes -February 14, 2026, at 10:00 a.m., thirty minutes The resident did not receive a bath of shower for greater than twenty days. Additional service delivery records indicated the licensee staff documented consistently provided grooming and dressing assistance. The records failed to indicate R1 refused these services. R2 R2 admitted to the licensee for diagnoses including diabetes, and heart failure. R2's master care plan with services/service plan dated March 25, 2026, indicated R2 required bathing assistance twice weekly, and staff were to provide nail care if needed. On June 3, 2026, at 8:27 a.m., the surveyor observed unlicensed personnel (ULP)-A provide dressing assistance to R2. While ULP-A helped apply R2's socks, R2 told her to be careful with his foot because his ankle hurt. The surveyor observed R2's feet and saw his nails were thick and overgrown. R2 told the surveyor he did not receive services from a podiatrist, and the licensee staff had not cut his nails. R3 R3 admitted to the licensee for diagnoses including Alzheimer disease and peripheral	01640		

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01640	Continued From page 5 vascular disease (circulation disorder). R3's master care plan with services/service plan dated March 14, 2026, indicated R3 required bathing/shower assistance three times a week and staff were to provide nail care if needed. On June 3, 2026, at 10:08 a.m., the surveyor observed R3 with his family. R3's family showed the surveyor R3's hands. R3's fingernails were long and overgrown. The surveyor observed dirt/soil embedded under R3's overgrown nails. On June 10, 2026, at 3:32 p.m., ULP-D said R1 did not talk much and preferred to be alone in his room. ULP-D said R1 had incontinent episodes of both urine and stool and required assistance with bathing/showering. ULP-D said it was difficult to get R1 into the shower and he required help washing. ULP-D said they had to physically wash R1's skin, he did not participate in bathing, or only participated minimally. ULP-D said if R1 refused to shower/bath, he gave this information verbally to the oncoming shift. ULP-D said he did not see the bandage on R1's arm. On June 11, 2026, at 12:33 p.m., registered nurse (RN)-F said R1 did not socialize much and spoke minimally. R1 did not like to participate in daily cares and required a lot of encouragement. RN-F said a few days before R1 went to the hospital, R1's health declined, and he was not eating very much food. RN-F said he was at the facility almost daily and R1 stayed in bed most of the time. RN-F said he assessed R1 after his hospital stay and observed R1's skin. RN-F said R1's skin was pretty much healed and only had a few scabs to the area where the bandage was. RN-F said there was no bleeding or drainage from R1 skin. RN-F said R1's skin appeared mostly healed.	01640		

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01640	Continued From page 6 RN-F said the licensee told the lab company to only use a cotton ball and band-aid to resident's skin after blood draws. RN-F said ULP's were supposed to remove the band-aid after blood draws and said some resident's can remove this themselves. RN-F was unsure if staff were supposed to remove Coban dressings. On June 11, 2026, at 1:18 p.m., during a follow up compliance interview, RN-F said R2 was diabetic, so the nurse was responsible to cut his nails. RN-B said R2 was a new resident, so RN-F had not cut his nails. (R2's admission date was March 13, 2026). RN-F said he cut R3's nails a few times, but it "was an aide thing." RN-F said the licensee had no formal process in place for staff to observe/address resident's nails. On June 16, 2026, at 2:33 p.m., manager (M)-G said she spoke to licensee staff and reviewed documentation after R1 returned from the hospital. M-G said she discovered ULP's documented they provided showering/bathing services when they had not performed them. M-G said the licensee's documentation was inaccurate because ULP's told her they did not know how to document "refusals". M-G said ULP's were expected to remove the Coban dressing/bandage if they saw it. M-G said the licensee asked to lab to only place a cotton ball, and band-aid to residents after blood draws. M-G acknowledged staff should remove these bandages as well. M-G said the licensee expected ULP's to do a skin observation/inspection when they give residents showers. M-G said ULP's left clothing on R1's bed if he had not changed clothing, so other staff would know they needed to attempt to change his clothing. M-G said if R1 refused bathing, staff verbally reported this information to other staff.	01640		

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01640	Continued From page 7 The licensee's policy titled, Service Plans, dated June 2, 2022, indicated the licensee would implement and provide all services unless unable for reasons such as resident refusal. Time period for correction: Twenty-One (21) days	01640		
02360	144G.91 Subd. 8 Freedom from maltreatment 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. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident(s) reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		