DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL305531420M
Compliance #: HL305535820C

Date Concluded: June 10, 2026

Name, Address, and County of Licensee Investigated:
A Pleasant Senior Living
41 Brand Ave
Faribault, MN 55021
Rice County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Brandon Martfeld, 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 facility neglected the resident when facility staff failed to follow the resident's plan of care and provide necessary care and services to the resident's left leg wound.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. There was not a preponderance of evidence that staff did not provide necessary cares or services. The resident developed a leg wound, the facility coordinated additional services with a homecare agency to assist with wound care. There were conflicting reports to indicate the wound care order was changed multiple times by the homecare agency but not communicated to the facility. The resident declined wound care at times and his health declined. The resident passed away while receiving hospice services.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted a homecare nurse. The

investigation included review of the resident records, death record, hospital records, homecare and hospice records, staff schedules, and related facility policy and procedures. Also, the investigator observed residents and staff at the facility.

The resident resided in an assisted living facility. The resident's diagnoses included hypertension (high blood pressure), chronic kidney disease, severe anemia (blood lacks enough healthy red blood cells to carry oxygen), lower gastrointestinal bleed, severe peripheral arterial disease, and heart failure. The resident's service plan included assistance with applying and removing compression stockings, behavior support, and medication administration. The resident's assessment indicated the resident was alert, orientated, and independent with toileting, bathing, mobility, and walked with a walker.

The resident's medical record indicated the resident developed a venous stasis ulcer (slow-to-heal, open wounds typically located on the lower leg or ankle. Caused by chronic venous insufficiency, where weakened vein valves cause blood to pool, increase pressure and damage skin tissue). When the resident's wound developed, the facility notified the primary care provider, and received orders for homecare services, and for a daily wound care order that consisted of the wound to be covered with an abdominal pad, wrapped with medical gauze and covered with a compression stocking. The resident's medical record indicated homecare services started four days after the wound developed. Two days after homecare services began, the resident's wound care order was changed to remove old dressing, wash wound with soap and water, pat dry, and apply foam border dressing and change two to four times a week, depending on drainage.

The resident's medical record lacked evidence the new wound care order was communicated or provided to the facility. The medical record lacked evidence the new wound order was implemented.

The resident's medical record indicated two days later; the resident was sent to the emergency room from the facility for leg pain. The resident returned to the facility on the same day and was started on a medication called Gabapentin (a nerve pain medication).

Five days after the resident returned from the hospital, the homecare agency changed the wound care order to remove old dressing, apply gauze soaked in a professional-grade, saline-based wound cleanser to the wound for 10 to 20 minutes, pat wound dry, apply thin coat of barrier cream to wound edges, apply a highly absorptive antibacterial foam wound dressing to wound bed, apply gauze or abdominal pad and secure with gauze. A homecare nurse was to complete dressing changes for the resident every day.

The resident's medical record lacked evidence the new wound care order was communicated or provided to the facility. The medical record lacked evidence the new wound order was implemented.

The resident’s medical record indicated the resident began hospice services five days later and passed away four days after beginning hospice services.

The resident’s death record indicated the resident’s cause of death was respiratory failure, heart failure and kidney failure.

During an interview, a homecare nurse stated the resident had a wound on his left leg that developed from swelling in his legs. The homecare nurse stated she saw him two or three times a week at first, but then the wound progressed fast, and wound care was needed every day. The homecare nurse stated that when the resident’s wound care order was changed, a fax would be sent to the facility updating them of the wound care changes.

During an interview, a facility nurse stated facility staff along with nurses from the homecare agency completed the resident’s wound care. The nurse stated the homecare agency usually faxed an order to the facility notifying them of the update. The facility nurse stated the facility did not receive any faxes or updates from the homecare agency that the resident’s wound care order had changed.

During an interview, facility leadership stated the resident refused to wear compression stockings to help reduce swelling in his legs, smoked cigarettes, and drank alcohol. When the resident developed a wound to his left leg, he was more worried about pain management than wound healing and at times would refuse wound care.

During an interview, a family member stated the resident always had a wound dressing in place and that the wound dressing would become soaked from the wound. At times, the resident would remove the wound dressing himself. The family member stated the resident had a long history of medical issues leading up to the resident passing away with hospice services.

In conclusion, the Minnesota Department of Health determined neglect 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.

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. The resident was deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
When the resident developed a wound on his left leg, the facility updated the primary care provider, obtained orders for wound care and homecare. The facility also encouraged the resident to seek treatment from 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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30553	A. BUILDING: ______ B. WING ______	C 05/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A PLEASANT SENIOR LIVING LLC	41 BRAND AVENUE FARIBAULT, MN 55021

(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: #HL305531420M / #HL305535820C On May 26, 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 38 residents receiving services under the provider's Assisted Living license. The following correction order is issued/orders are issued for #HL305531420M / #HL305535820C, tag identification 1620.	0 000	Assisted Living Provider 144G. 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.	

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

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01620	Continued From page 1	01620		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be	01620		

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01620	Continued From page 2	01620		

completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review.
(f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to complete a change of condition reassessment for one of one resident (R1) who developed a wound and had increased pain.

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).

The findings include:

R1 was admitted August 23, 2024, and had diagnoses that included hypertension (high blood pressure), chronic kidney disease, severe anemia (blood lacks enough healthy red blood cells to carry oxygen), lower gastrointestinal bleed, severe peripheral arterial disease, and heart failure.

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R1's Service Plan dated January 19, 2026, indicated R1 received assistance with medication administration, applying and removing compression stockings, and behavior management.

R1's assessment for skin integrity dated December 24, 2025, indicated R1 had redness to lower legs, and dryness to the tip of the big toe on the left foot.

R1's progress notes dated January 16, 2026, indicated R1 developed a wound to the left leg. The progress note indicated a request to the primary care provider for wound care and homecare services. The wound care order was for the wound to be covered with an abdominal pad, wrapped with gauze, and covered with a compression stocking.

R1's progress notes dated January 24, 2026, indicated R1 had a change to his baseline that included severe pain to the left leg. R1 was transferred to the hospital for an evaluation. R1 returned to the facility the same day and was started on Gabapentin medication for leg pain.

R1's medical record lacked evidence of reassessment by a registered nurse (RN) after R1's wound developed and was sent to the hospital for increased leg pain.

During an interview on May 28, 2026, at 2:42 p.m., licensed assisted living director (LALD)-F stated R1's medical record was missing change of condition assessments.

The licensee's Assessments-Schedule policy dated December 2019, indicated a change of condition assessment would be completed by a

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01620	Continued From page 4 RN as indicated and that the immediate supervisor is responsible to ensure assessments of residents are completed according to regulations and follow up with non-compliance and/or disciplinary actions as necessary. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		