

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL368494862M
Compliance #: HL368491081C

Date Concluded: October 13, 2025

Name, Address, and County of Licensee

Investigated:

Personal Care Senior Living LLC
525 Cutter St
Anoka, MN 55303-2091
Anoka County

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

Evaluator's Name: Lori Pokela R.N.
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 facility neglected the resident when the resident's right, lower extremity wound dressing was found wet, soiled and covered in maggots.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined neglect was not substantiated. Facility staff followed the plan of care for the resident and reported concerns to the facility nurse. Although a wound was found with maggots, the wound was managed by the hospice agency nurses. The facility collaborated with the hospice agency in addition to the resident's provider and the wound was treated with an antibiotic.

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

investigator observed the facility physical plant, medication administrations, cares being given and interaction between residents and staff.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia and quadriplegia. The resident's service plan indicated the resident received services including wound care, three times per week and catheter care from a hospice agency. The resident's assessment indicated the resident was disoriented to time and place, the resident had memory deficits and a history of falls.

The resident's medical records indicated the facility nurse assessed the resident after the fall and treated his injuries. The resident's right lower wound dressings on his foot were wet with drainage. The facility nurse removed the resident's dressing on his right foot and found maggots in the wound. The wound was cleansed and rewrapped. The resident's catheter was also occluded with sediment and the catheter was changed. The facility nurse placed a call to the resident's hospice agency nurse to report the fall, wound and catheter care concerns. The facility nurse was advised the hospice agency nurse would come to assess the resident the day of the fall. The hospice agency nurse arrived the day after the fall to assess the wound, completed a post fall assessment and address the catheter concerns. Medical records had indicated the hospice agency nurse missed the scheduled dressing change visit prior to the fall. The medical provider was updated, and antibiotics were ordered for the wound.

During an interview a facility staff stated when there were concerns with the resident's wounds the facility nurse and hospice nurse were updated.

During an interview, the facility nurse stated when staff reported the resident's fall, the resident was found sitting on the floor of a facility dining room. The resident was found with a skin tear wound on the back of his head. The facility nurse called the hospice agency after the fall to report the resident's wound status and a second call to report the fall and urinary catheter concerns. The hospice agency nurse did not come to assess the resident the day of the incident. The hospice agency nurse came the following day and completed wound care and fall assessment follow-up.

During an interview, a facility administration nurse stated when he assessed the resident, he always had his wraps on, and dressings weren't removed because the hospice agency nurses fully managed the dressing changes.

During an interview, the resident stated he felt the cares he received at the facility was very good and he had no concerns.

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: Yes

Family/Responsible Party interviewed: No, family member declined to interview

Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:

The facility nurse assessed the resident's lower extremities and urinary catheter status notified hospice and completed an incident report regarding the resident's change in condition.

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: 36849	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/13/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER SUITE LIVING SENIOR CARE OF ANOKA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 525 CUTTER STREET ANOKA, MN 55303
--	---

(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>Initial Comments</p> <p>On August 13,2025, the Minnesota Department of Health initiated an investigation of complaint #HL368491081C/#HL368494862M. No correction orders are issued.</p>	0 000		

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