Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL393128002M
Compliance #: HL393128551C

Date Concluded: March 26, 2026

Name, Address, and County of Licensee Investigated:
Personal Care Senior Living Andover
14209 Inca St. NW
Andover, MN 55433
Anoka County

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

Evaluator's Name:
Jana Wegener, RN, Special Investigator

Finding: Substantiated, individual 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 resident was neglected when the alleged perpetrator (AP) failed to provide care and services for falls prevention, then failed to report the fall or resident's complaint of pain.

Investigative Findings and Conclusion: The Minnesota Department of Health determined neglect was substantiated. The AP was responsible for the maltreatment. Although the AP, an unlicensed personnel (ULP) documented completing safety checks and scheduled toileting, she admitted those services were not provided. A facility investigation indicated video surveillance showed the AP failed to provide scheduled toileting and supervision to ensure his safety. The resident was found on the floor with complaints of pain, but the AP put the resident back into bed and closed the door without providing pain management or reporting the fall to ensure the resident's pain and injuries were addressed. The resident record indicated he sustained a hip fracture with uncontrolled pain requiring transfer to the emergency department (ED), hospitalization, and surgical repair. The resident's record of death indicated he died a few days later from the fracture sustained during the fall.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family. The investigation included review of the resident record(s), death record, hospital records, hospice records, facility internal investigation, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed residents and staff in the secure memory care unit.

The resident resided in an assisted living facility secure memory care unit with diagnoses including dementia, and prostate cancer.

The resident's assessment and plan of care indicated the resident had moderately impaired cognition and was disoriented to person, place, and time and received hospice for end of life care. The assessment and care plan indicated the resident was not able to walk and was dependent on staff assistance with transfers toileting and incontinence care and mobilized using a wheelchair. The assessment and plan of care indicated the resident was at a risk for falls, with no falls in the last 3 months using interventions including visual hourly safety checks scheduled at 11:00 p.m., 12:00 a.m., 1:00 a.m., 2:00 a.m., 3:00 a.m., 4:00 a.m., 5:00 a.m., and 6:00 a.m. and toileting scheduled at 3:30 a.m. during the night shift. The plan of care directed staff to bring the resident to a common area to provide supervision if he was restless or agitated.

A concern arose when unlicensed personnel tried to get the resident up for the day, but he was in pain and unable to bear weight, which was a change for him. The resident was transferred to ED, and the facility began looking into how this change occurred.

A facility investigation indicated after interviewing multiple staff including the AP and reviewing video surveillance from 11:00 p.m. to 6:30 a.m. (the night shift when the fall incident occurred) showed the AP put the resident into bed and closed the resident's door around 11:00 p.m. The AP remained seated on the couch for the majority of her shift with the exception of providing limited rounds on some of the residents around 4:20 a.m., however the AP did not open the resident's door. Near the end of her shift the AP documented completing the resident's hourly safety checks on the resident, and when interviewed the AP stated that the safety checks were completed for the resident, however video surveillance showed the AP had not provided any of the safety checks or toileting she had documented as complete. It was further determined after another staff member found the resident on the floor of his room, screaming in pain around 5:00 a.m. when the staff went to get help, the AP put the resident back into bed without waiting for assistance and closed his door. The AP did not report the fall or pain to triage nursing before getting the resident off the floor, failed to report the fall and pain to hospice, management, or oncoming staff to ensure the resident's needs were met. Additionally, the AP did not complete an incident report or administer any pain medication and did not check on the residents again.

The resident's service delivery of care record included the scheduled toileting and safety checks. The AP documented completing all of the hourly safety checks and toileting at the same time at 5:43 a.m. (after the resident fell). However, the service delivery record indicated when day shift staff went to get the resident up for the day, he was unable to get out of bed and complained of hip pain.

A review of the incident reports indicated the AP did not complete an incident report regarding the resident's fall.

An incident report was filled out a day later by someone other than the AP. The incident report indicated the resident had an unwitnessed fall after transferring himself to the bathroom without staff assistance and was found lying on the floor near his bed. The incident report indicated vitals were taken (not recorded in the resident record) and the resident was put back into bed, but the fall was not reported to the nurse. The incident report indicated the resident's sustained a hip fracture from the fall.

A review of the progress notes did not identify documentation by the AP of the resident's fall nor complaint of pain. Additionally, the same review found no indication the AP informed the triage nurse nor hospice of the fall. The progress indicated the day shift caregivers found the resident in pain and unable to get out of bed. When a hospice RN assessed the resident in the morning the resident had pain and abnormal internal rotation of his hip. The progress notes indicated an Xray was ordered, and pain management was provided but the resident's pain was unable to be managed at the facility.

At around 1 p.m. the X-ray results came back and indicated the resident sustained an acute intertrochanter fracture of the left hip.

The resident's hospital record indicated the resident's required transfer to the ED/hospital for pain management and indicated the resident's pain remained unmanageable despite intravenous pain medication. Although the ED/hospital record mentioned the residents' hip fracture was possibly a pathological fracture (a fracture caused by disease processes weakening the bone structure) there was no evidence of or other mention of a pathological fracture in the resident's record, radiology reports, or surgical notes reviewed. The ED/hospital record indicated the resident had surgical repair (internal fixation) to stabilize his hip fracture and was readmitted to the facility with hospice services.

After approximately four days, the resident returned to the facility. Three days after that the resident died.

The resident's record of death indicated the resident's immediate cause of death was a left hip fracture from an unwitnessed fall at the facility.

When interviewed facility leadership stated the AP admitted she knew the resident needed to be checked on, toileted, and the resident was in pain after he fell and should have reported the incident but did not.

When interviewed, unlicensed personnel (ULP) #1 stated she went to the resident's room at 5:00 a.m. to borrow an incontinence brief for another hospice resident and the resident was laying on the floor screaming in pain. ULP#1 stated she notified the AP of the fall and instructed her to call triage while she went to get another staff to ensure they had enough help to get the resident off the floor. ULP#1 stated when she returned the AP had put the resident back in bed and closed his door. ULP#1 indicated she thought the AP had called triage to report the fall.

During an interview, ULP#2 stated when she came on shift in the morning the AP reported to her, she had "No falls", which she thought was strange because normally staff would only report if a fall occurred. ULP#2 stated as she settled in for her shift the resident was heard in his room making loud noises, which was not normal for him, so she immediately went to check on him. ULP#2 stated the resident was in severe pain and stated, "I hurt right here" and placed ULP#2's hand on his hip area. ULP#2 then called hospice and provided pain medication (over 2 hours after the resident fell with complaints of pain).

When interviewed ULP#3 stated she had a brief encounter with the AP the morning after the incident and asked her how her night was. The AP responded "Good, no falls". ULP#3 stated she thought it was unusual but did not think anything of it until the resident was unable to get out of bed and she later learned the resident had fallen and fractured his hip.

When interviewed the AP stated she was trained and knew what to do for the residents and in the event of a fall. The AP stated she did not provide safety checks, toileting, nor did she report the resident's fall.

When interviewed the resident's family stated although the resident was on hospice prior to the fall. The family stated the resident received aggressive pain management following the fall to try to keep him comfortable, but the resident would scream with any movement and was transferred to the hospital where he ultimately underwent surgical repair to stabilize his hip fracture. The family stated the resident returned to the facility on hospice where his condition deteriorated and he died.

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: Yes

Action taken by facility: The facility suspended the AP, investigated the incident, and reported the incident to the Minnesota Adult Abuse Reporting Center (MAARC). The AP is no longer employed by the facility.

Action taken by the Minnesota Department of Health:
The facility was issued a correction order regarding the vulnerable adult's right to be free from maltreatment.

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

You may also call 651-201-4200 to receive a copy via mail or email.

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Anoka County Attorney
Andover City Attorney
Andover Police Department
Department of Human Services (DHS)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39312	A. BUILDING: _____ B. WING _____	C 01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSONAL CARE SENIOR LIVING LLC	14209 INCA STREET NW ANDOVER, MN 55304

(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****** HOME CARE PROVIDER/ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144A.43 to 144A.482/144G.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: #HL393128002M/#HL393128551C On January 27, 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 30 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued/orders are issued for #HL393128002M/#HL393128551C, tag identification 2360.	0 000		
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	02360		

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02360	Continued From page 1 covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: Based on interviews and document review, the licensee failed to ensure one of one residents (R1) reviewed was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, an individual person was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please see the Public Maltreatment report for details.	02360		