

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report : HL393123589M
Compliance : HL393123144C

Date Concluded: September 14, 2026

Name, Address, and County of Licensee

Investigated:

Personal Care Senior Living
14209 Inca St NW
Andover, MN 55433
Anoka County

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

Evaluator's Name: Deb Schillinger RN BSN
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 alleged perpetrator (AP) abused the resident when was viewed on video footage striking the resident's arm twice, then grabbing her arm and pulling her from a room.

Investigative Findings and Conclusion: The Minnesota Department of Health determined abuse was substantiated. The AP was responsible for the maltreatment. The AP hit the resident twice forcefully and then pulled the resident from the room by her right wrist causing bruises.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement. The investigation included review of the resident record, facility internal investigation, facility incident reports, personnel files, staff schedules, law enforcement report, and related facility

policy and procedures. Also, the investigator observed interactions between residents and facility staff during an onsite visit.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia. The resident's service plan included assistance with medication management and administration, toileting and safety checks. The resident's assessment indicated she was able to walk independently, was disoriented to time and place and wanders freely on memory care unit, at times into other resident's rooms requiring redirection.

A concern arose when a video was provided to facility managers from the room of another resident's family member, which showed the AP struck the resident on the right upper arm twice forcefully then grab her right wrist area, pulling her out of the room causing bruising.

The video showed the resident in another resident's room touching and rearranging a black shirt or sweater on the end of the bed. The AP entered the camera view and grabbed the resident's right forearm. The resident pulled away from the AP's grasp and slapped at the AP's hand. The AP then using excessive force hit the resident with an open hand on the right upper arm twice, causing the resident to struggle and attempt to defend herself, then the AP grabbed the residents right wrist area pulling her out of the room.

Photos taken the next day showed bruising to the resident's right wrist area in the same area the AP grabbed her and pulled her out of the room.

The AP education transcript indicated dementia training and vulnerable adult training was completed by the AP two months prior to the incident.

The police report indicated the AP stated the VA was angry and hit AP on hand when she tried to remove her from the other resident's room. AP stated she tickled the resident to get her out of the room then grabbed her hand.

During an interview, the nurse stated the video was sent to her the day after the incident. After reviewing the video, she immediately started the investigation, including suspending the AP. The resident was assessed and bruising was noted to the residents right wrist area and photos were taken. The AP was terminated and reeducation was provided to the remaining facility staff on vulnerable abuse identification and reporting.

During an interview, the AP stated she found the resident in another room putting another resident's clothes on the floor. The AP stated she tapped the resident on the hand, then the resident started yelling at her and hurting her. The AP denied hitting the resident, she stated the resident was throwing other resident's things on the floor. The AP stated she did not see the video footage from the other residents room and later denied having received abuse training.

In conclusion, the Minnesota Department of Health determined abuse 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.

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: No, due to cognitive impairment

Family/Responsible Party interviewed: Yes

Alleged Perpetrator interviewed: Yes

Action taken by facility: The facility completed an investigation, suspended and later terminated the AP and reeducated the staff on vulnerable adult abuse.

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
Department of Human Services (DHS) Background Study Unit
Anoka County Attorney
Andover City Attorney
Andover Police Department
Anoka Sheriff's Department

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39312	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/28/2026
NAME OF PROVIDER OR SUPPLIER PERSONAL CARE SENIOR LIVING LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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***** 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: #HL393123144C/#HL393123589M On July 28, 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 32 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL393123144C/#HL393123589M, 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 covered under the Vulnerable Adults Act.	02360			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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02360	Continued From page 1 This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual person was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360			