Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL414909202M
Compliance #: HL414903125C

Date Concluded: June 24, 2026

Name, Address, and County of Licensee Investigated:

Amazing Grace Care LLC
7988 Hallmark Way
Apple Valley, MN 55124
Dakota County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Willette Shafer, RN
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 alleged perpetrator (AP) neglected the resident when the AP failed to ensure the resident's wound care was completed per the provider's orders.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. When the resident admitted to the facility she had a self-inflicted wound on her wrist and a chronic wound due to medical issues on her foot. The AP, who was also the owner, completed wound care according to the provider's orders. The resident often refused services, including dressing changes. The facility documented the resident's noncompliance with treatment. Within weeks of the resident's admission to the facility, a wound care agency began treating the resident's wounds. The resident's hand wound was healing, and her foot wound remained mostly unchanged when wound care began treating her wounds. When a second area of concern

developed on the resident's foot the AP requested podiatry services. The wound care agency was discontinued when podiatry services began.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's case manager and wound care agency nurse. The investigation included review of the resident record, hospital records, facility incident reports, personnel files, staff schedules, and related facility policy and procedures.

The resident resided in an assisted living facility. The resident's diagnoses included bipolar disorder, depression, diabetes, peripheral artery disease, and anxiety. The resident's service plan included assistance with medication management, wound care, catheter care, behavioral monitoring, safety checks, bathing, grooming, and transfer assist of one with mechanical standing lift.

The resident's wound care orders after discharging from the hospital directed staff to change the resident's heel dressing daily and her hand dressing three times a week.

The resident's wound care notes indicated a nurse changed the resident's heel dressing daily and her hand dressing three times a week.

The resident's service delivery record indicated both dressing changes were documented as completed per the resident's wound care orders.

The wound care assessment completed by the nurse upon admission indicated the wound on the resident's hand measured 9 centimeters (cm) x 3 cm x 0.2 cm (depth). The wounds were reassessed and measured one month later. Her hand wound measured 5.7 cm x 2.9 cm x 0.2 cm. The resident's wound was healing noted by a decrease in wound size. The wound care assessment indicated the resident's heel wound upon admission measured 4 cm x 3.5 cm. One month later, her heel wound size remained unchanged noted by the same measurements. After one month of living at the facility, the wound care agency began managing the resident's wounds and completed scheduled dressing changes.

During an interview, the resident said she was unhappy living at the facility. She said she used to work for Occupational Safety and Health Administration (OSHA) in the past and she observed five violations when she first entered the facility. She said the main two care providers were married. One was a nurse and owned [the AP] the facility. She said this concerned her because a nurse was not allowed to own an assisted living. She called the police multiple times for various reasons whiling resident at the facility. Her other concerns included doors opening in the wrong direction, groceries and flavor of the food, barriers blocking fire exits, wrong medication, and incomplete hygiene care. She said her wounds were managed by a wound care agency and podiatry. When the facility changed her dressings it was mainly completed by the AP. She said a different nurse who worked for the facility came every Thursday and changed her

dressings. The wound care agency provided dressing changes twice a week to her heel and the AP changed her foot dressing once a week. She said heel wound was supposed to be changed more frequently. She reported concerns about several other facilities she resided at. She said a 'reputable hospital' created the wounds on her foot and she self-inflicted the wounds on her hand. She said she tried to commit suicide because the prior facility she lived in "was so bad."

During an interview, the AP said the resident had a chronic wound on her foot and a self-inflicted wound on her hand when she was admitted. The wound on the resident's foot was monitored by wound clinic. When the resident admitted, the AP requested wound care manage the resident's wounds. The resident's insurance approved the wound care referral roughly one month after she admitted to the facility. The wound care agency managed the resident's wounds for a couple months while podiatry was set up for the resident. The AP said finding a wound care agency was difficult as several agencies denied the resident because of other behaviors. The facility nurse's completed wound care according to the provider's order and as needed when the wound care agency was unavailable. The AP was knowledgeable about the residents wound care orders and treatment. The AP and nurse completed dressing changes and assessments. The self-inflicted wound on the resident's hand was fully closed before the resident was discharged from the facility. The resident declined services including wound care at times. She said she worked closely with the resident's case manager to ensure continuity of care and individualized treatment for success.

During an interview, the nurse said she completed the resident's wound assessments and several dressing changes while the resident was admitted. She said wound care services were established with an outside provider a few weeks after the resident was admitted to the facility. While the resident was enrolled with the outside wound care agency, the agency still completed some of the resident's dressing changes. The wound care agency's services were discontinued when the resident established care with podiatry.

During an interview, the wound care nurse said he completed wound care for eight weeks. The wound care agency changed the resident's dressing on her foot twice a week and the third dressing change was completed by facility staff. He said the facility changed the dressing consistently on their scheduled day. He said the resident was not compliant with caring for her feet. He encouraged the resident to wear shoes, but the resident declined. The wound care agency provided short-term care, usually when a resident was between providers. The resident's wound care services were discontinued once she was enrolled with podiatry (specialized medical services focused on managing leg/foot care).

During an interview, the resident's case manager said the resident's behaviors were challenging at times. The resident had a history of being untruthful and making false allegations. The case manager cited several specific incidents when the resident was dishonest. The case manager had difficulty finding providers who were willing to provide service to the resident because of her behaviors and noncompliance.

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, the resident declined a family interview.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility implemented numerous medical and behavioral interventions. The facility worked closely with other members of the resident’s interdisciplinary team to ensure optimal mental and physical health care. The facility secured a wound care agency to manage the resident’s wounds and establish podiatry services for the resident.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41490	A. BUILDING: _____ B. WING _____	C 05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMAZING GRACE CARE LLC	7988 HALLMARK WAY APPLE VALLEY, MN 55124

(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 On May 28, 2026, the Minnesota Department of Health initiated an investigation of complaint #HL414903125C/HL414909202M. No correction orders are issued.	0 000		