Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL201912143M
Compliance #: HL201912712C

Date Concluded: June 6, 2025

Name, Address, and County of Licensee Investigated:
Burnsville Carefree Living
600 E. Nicollet Blvd.
Burnsville, MN 55337
Dakota County

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

Evaluator's Name: Michele Larson, 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 facility neglected the resident when the resident missed five days of her scheduled narcotic pain medication (hydrocodone) because the facility ran out of the resident's scheduled narcotic pain medication. In addition, the facility neglected the resident when they failed to supervise and monitor the resident. The resident was found with lit candles in her room, violating the building fire code.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The resident missed days of hydrocodone due to changing providers and health insurance not due to facility neglect. The resident changed health insurance companies twice within one month and waited to establish care with a new medical provider which delayed the start of the resident's hydrocodone being refilled by her new provider. The resident's new medical provider prescribed a weeks' worth of the resident's hydrocodone until she scheduled an in-person visit.

The Minnesota Department of Health determined neglect of supervision was not substantiated. The facility monitored the resident's apartment, but the resident ordered candles and lighters from an on-line shopping site without the facility's knowledge. The facility and fire department confiscated the candles and lighters from the resident's apartment prior to the investigator's on-site visit. The investigator observed no candles or lighters during two separate visits to the resident's apartment.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The resident was interviewed. The investigator contacted the resident's former and current case managers, and fire department. The investigation included review of the resident record, previous in-house provider's record, case management record, physical therapy record, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed staff and resident interactions during the onsite investigation.

The resident resided in an assisted living facility. The resident's diagnoses included morbid obesity, chronic joint pain (osteoarthritis), major depressive disorder, Bipolar disorder, and Post-Traumatic Stress Disorder (PTSD). The resident used a manual wheelchair and a four wheeled walker for mobility. The resident's service plan included assistance with personal cares, medication administration, and three daily safety checks. The resident's assessment indicated the resident was alert and oriented to person, place, time, and situation. The resident was independent with walking and bed mobility but required stand-by assistance with transfers.

The resident's medication administration record indicated staff administered daily medications to the resident which included scheduled hydrocodone three times a day (10:00 a.m., 2:00 p.m., 7:00 p.m.), in addition to as needed (prn) hydrocodone every six hours.

The resident's in-house medical provider notes dated February 2025, indicated the resident's medical provider notified the resident her services with the in-house medical provider would be terminated in 30 days. The medical provider indicated the inability to achieve and maintain rapport with the resident along with the resident not adhering to her behavioral plan as reasons for terminating services. The medical provider indicated they would continue to provide continuity of care and any needed pharmacy prescriptions for an additional 30 days. The resident was encouraged to find a new medical provider as soon as possible.

The resident's progress note indicated one month later the resident's medical provider refilled the resident's hydrocodone prescription. The resident's provider indicated they would sign-off as the resident's medical provider once the resident scheduled an in person visit with the new provider. Two days later the resident had a telehealth visit with her new medical provider but did not schedule an in-person visit.

The resident's record indicated days after the resident's services were terminated with her medical provider the resident received notice her health insurance would change to a new

insurance company at the beginning of April 2025. The day after the resident switched health insurance companies, the resident contacted her case manager, requesting yet another change to a different health insurance company.

The resident's record indicated three weeks later the resident ran out of hydrocodone. The resident called 911 to be transported to the hospital to get more hydrocodone.

Review of the resident's emergency department (ED) record indicated the resident presented to the hospital three times in three days requesting hydrocodone for her chronic pain. The ED indicated the resident changed primary care providers and had no provider to refill her chronic pain medication. The ED staff contacted the facility who indicated they would welcome the resident back to the facility but reported the resident's behaviors at the facility were problematic. When interviewed by ED staff the resident stated she did not have any more refills of her hydrocodone due to "firing" her last provider. The resident stated she had a new provider but had not yet scheduled an in-person visit to obtain prescription refills. The hospital refused to refill the resident's pain medications and declined to administer narcotic pain medications in the ED. A few hours later the resident was discharged back to the facility with prescriptions for a non-steroidal anti-inflammatory drug (Toradol) for moderate to severe pain, and a topical pain patch (Lidoderm 5%). An ED doctor ordered outpatient primary care follow-up with her new provider indicating the provider's care team would call the resident to arrange an appointment within the next week.

When interviewed, a facility nurse stated the resident was in-between providers at the time the resident ran out of her hydrocodone. The nurse stated he ordered another refill of the resident's hydrocodone two days before she ran out but stated the resident's new provider would not renew her prescription until he physically saw the resident.

When interviewed, the resident stated she thought she missed only a few days of hydrocodone and was unsure when she ran out stating she thought her new provider prescribed a week's worth of hydrocodone the last week of April until an in-person visit but was unsure. The resident stated the ED staff treated her like an addict and refused to administer any narcotic pain medication. The resident gave conflicting statements when she first stated she was not addicted to opioids but later stated she was physically addicted to hydrocodone stating, "If you just cut me off of this I will go into withdrawal."

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" 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: Yes
Alleged Perpetrator interviewed: Not applicable.

Action taken by facility:
Facility nursing staff tried to reorder the resident’s pain medication before she ran out.

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
	20191	A. BUILDING: _____ B. WING _____	C 05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BURNSVILLE CAREFREE LIVING BY OXFORD	600 EAST NICOLLET BOULEVARD BURNSVILLE, MN 55337

(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, this correction order is 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: #HL201913767C/#HL201912143M #HL201913367C/#HL201911982M On May 13, 2025, 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 66 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for #HL201913367C/#HL201911982M, tag identification 2310 and 2360.	0 000		
02310 SS=G	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date	02310		

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02310	Continued From page 1 service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide care and services according to acceptable health care, medical or nursing standards for one of one resident (R1) with record reviewed for falls. R1 fell and fractured her left forearm and left lower leg bone (fibula) while attempting to toilet herself. The facility failed to provide R1 with a means to contact staff for assistance when she fell. R1 was transported to the hospital to receive treatment for her fractured arm. In addition, the licensee failed to ensure R1 was assessed by a facility registered nurse (RN)-D after R1 was discharged from the hospital after fracturing her arm. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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's record was reviewed. R1 was admitted to the licensee's facility on July 30, 2024. R1's diagnoses included but were not limited to unspecified intracranial injury with loss of consciousness (damage to the brain inside the skull and inability to be aware of oneself and surroundings), muscle weakness, epilepsy (seizures), unsteadiness of feet, and repeated	02310		

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02310	Continued From page 2 falls. R1 used a walker and wheelchair for mobility. R1's service plan dated July 30, 2024, indicated R1 received assistance with personal cares, medication, meals, transfers and toileting. In addition, R1 was supposed to receive hourly safety checks to help prevent frequent falls. During the hourly checks staff were to ensure R1's call pendant worked and R1 wore the call pendant. If R1 was not wearing her call pendant staff were to help locate her pendant, re-educate R1 on the benefits of wearing the pendant, or notify a supervisor immediately if her call pendant was not working. R1's assessment dated February 6, 2025, indicated R1 was able to make her needs known and be understood, but her cognition was moderately impaired. R1's fall assessment score indicated she was at risk for falls. R1's fall incident report dated March 8, 2025, at 8:12 a.m., indicated R1 fell in the bathroom while transferring herself from her wheelchair to the toilet. Vitals were obtained. No injuries were observed and R1 reported no pain. Staff reported R1 used her call pendant to request staff assistance. R1's progress note dated March 26, 2025, at 1:48 p.m., indicated R1 said she slipped and fell in her bathroom then dragged herself into the main area of her apartment where she was found by staff. Staff lifted R1 back into her wheelchair. Staff educated R1 about having staff present while performing personal cares. R1 verbalized understanding. No vitals were obtained. Staff did not document if R1 did or did not sustain injuries from her fall. R1's record lacked evidence her call	02310		

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02310	Continued From page 3 pendant was available to her to call staff for assistance. R1's fall incident report dated April 1, 2025, at 8:30 p.m., indicated staff found R1's wheelchair near her bathroom door and R1 naked on the bathroom floor. R1 told staff she wanted to take a shower. Two staff assisted R1 off the floor after no apparent injuries noted. R1's vitals were not obtained. R1's fall incident report lacked evidence R1 had her call pendant available to call staff for assistance. Another fall incident report dated April 8, 2025, at 3:45 a.m., indicated staff found R1 on the bathroom floor in front of her toilet. R1 told staff she missed the toilet seat and fell. R1 reported pain. Staff observed R1's legs and right arm were swollen. At 4:20 a.m., emergency medical services (EMS) arrived and transported R1 to the hospital emergency department (ED). The incident report lacked evidence R1 had her call pendant available to call for staff assistance. R1's ED record dated April 8, 2025, at 4:53 a.m., indicated R1 suffered a fall while trying to get out of bed. R1 complained of neck, abdominal, back, and left arm and ankle pain and rated her pain severe (7/10). Images (x-rays) obtained indicated R1 suffered an acute fracture of a left lower forearm bone (radius) as well as a chronic fracture of the left upper forearm bone (humerus) near the elbow. R1's left arm was placed in a sling with instructions to avoid heavy weight bearing until her follow-up appointment with orthopedic surgery. R1 was prescribed a strong narcotic pain medication (hydrocodone) before being discharged back to the facility. R1's record lacked evidence R1 was reassessed	02310		

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02310	Continued From page 4 by RN-D upon her return to the facility. R1's orthopedic outpatient record dated April 11, 2025, at 12:39 p.m., indicated during R1's follow-up evaluation, R1 reported pain in her left ankle. X-rays indicated R1 also broke a left lower leg bone (fibula) near her left ankle. R1 was required to wear a fracture (walking) boot for four weeks with weight bearing as tolerated and her wheelchair for long distances. During in interview on May 13, 2025 at 2:45 p.m., R1 stated the facility did not have a call system for her prior to her fall, stating she "hollered" for staff assistance if she needed them. R1 stated she did not recall how long she was without her call pendant but thought it was a week. R1 stated at times it took staff a while to respond to her yelling, stating she sometimes urinated on the floor because she had to wait for staff. R1 stated since the fracture she still had pain in her left arm and was unable to sleep on her left side. On May 13, 2025, at 3:30 p.m., the investigator requested R1's call pendant report for a two-week time frame surrounding R1's fall from April 1, 2025-April 15, 2025. In addition, the investigator requested RN-D to check if R1 had a call pendant. During an interview on May 14, 2025, at 9:00 a.m., licensed practical nurse (LPN)-B stated R1 knew how to use her call pendant and to call for help. During an interview on May 14, 2025, at 11:35 a.m., R1's legal guardian (LG)-C stated R1 misplaced items frequently. LG-C stated staff were supposed to make sure R1's pendant was either on her or her wheelchair.	02310		

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02310	Continued From page 5 In an email dated May 19, 2025, at 1:40 p.m., from RN-D to the investigator, RN-D attached R1's requested call pendant report for the two-week time frame surrounding her fall. Review of R1's call pendant report indicated R1 never used her call pendant within the two-week time frame. In a follow-up phone call dated May 20, 2025, at 12:26 p.m., RN-D stated R1 did not have a call pendant but stated they immediately provided a pendant to R1 after the investigator left the facility. In an email from the investigator to RN-D dated May 29, 2025, at 6:48 a.m., the investigator requested a second call pendant report dated May 14, 2025 through May 28, 2025, the day after R1 received a call pendant from the facility. On May 29, 2025, at 10:39 a.m., the investigator received R1's second call pendant report. Review of R1's second report indicated R1 used her call pendant several times to request staff assistance during different times of the day. During an interview on May 29, 2025, at 11:23 a.m., RN-D confirmed she did not reassess R1 and was unaware it was in the Minnesota Assisted Living 144G statutes that ongoing resident reassessment and monitoring must be conducted based on a change in the a residents condition. The licensee's policy titled Assessments, Reviews, and Monitoring, updated January 16, 2023, indicated resident monitoring and review must be conducted as needed based on changes in the needs of the resident and were not to	02310		

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02310	Continued From page 6 exceed 90 calendar days from the date of the last review. Review of current plan of care, and if needed a reassessment would be done following a change in condition including but not limited to falls. TIME PERIOD FOR CORRECTION: Seven (7) days.	02310		
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. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident(s) reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		