

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL201912982M
Compliance #: HL201911615C

Date Concluded: September 10, 2026

Name, Address, and County of Licensee

Investigated:

Carefree Living Burnsville
600 E Nicollet Blvd,
Burnsville, MN 55337
Dakota County

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

Evaluator's Name: Brandon Martfeld, RN,
BSN, 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 overall poor condition of the facility resulted in the resident's fall.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined neglect was not substantiated. The resident was independent with transfers and walking and had an unwitnessed fall outside of the facility on a sidewalk. The resident was able to get himself off the ground independently. The resident did not report the fall immediately and did not seek medical attention until days later. Although the concrete sidewalk had deteriorated, there was not a preponderance of evidence that the fall occurred because of the sidewalk condition.

The investigator conducted interviews with facility staff members, including administrative staff, and nursing staff. The investigator contacted the case worker. The investigation included review

of the resident records, hospital records, facility incident reports, staff schedules, and related facility policy and procedures. Also, the investigator observed the facility's sidewalk area.

The resident resided in an assisted living facility. The resident's diagnoses included osteoporosis, dementia, and anxiety. The resident's service plan included assistance with showering and medication administration. The resident's assessment indicated the resident was alert, oriented, and was independent with transferring and walking. The resident's assessment indicated the resident did not require any walking or transferring devices and was not at risk of falling.

An incident report indicated the resident went to a facility nurse a day after he had slipped and fell on the sidewalk. The incident report indicated the resident hurt his thumb and bruised his ribs. The resident denied injury anywhere else. A nurse advised the resident to seek care at a hospital, but the resident declined.

Progress notes indicated the resident slipped and fell while walking outside of the facility. The resident was advised to go to the hospital, however the resident declined. Three days later the resident was seen at an urgent care and was diagnosed with a left hip fracture and was given pain medication. The progress notes indicated the resident had hip surgery approximately 12 weeks later.

The hospital record indicated three days after falling, the resident was seen in the hospital and had an x-ray completed. The resident x-ray indicated the resident had a nondisplaced left hip fracture, pelvis fracture and a left wrist fracture. The resident was prescribed pain medication and scheduled for surgery. The surgery was completed approximately 12 weeks later. The hospital record indicated the resident had age-related osteoporosis with current pathological fracture (a person had advanced bone loss (osteoporosis) which has caused a bone to break (pathological fracture) from a minor stress or low-impact event, such as a normal daily activity, a minor bump, or a simple fall from standing height). The resident discharged back to the facility following surgery.

During an interview, facility leadership stated the resident's fall occurred on the sidewalk that cuts between the facility and city property. The fall was not observed by staff, the resident was able to get himself up, and when the nurse was made aware of the resident's fall, she completed an assessment. The resident denied seeking care immediately but eventually went to the hospital to be evaluated.

During an interview, a nurse stated the resident fell outside on the sidewalk and then a few days later the resident went to the hospital. The resident was found to have a fractured hip. The nurse stated the resident walked independently without any walking devices.

During an interview, the resident stated he was coming back from the grocery store and walked up the sidewalk that led from the city sidewalk to the facility sidewalk. The resident stated the

sidewalk had some snow on it, and when he got to the top of the sidewalk, he fell. The resident stated he was able to get himself up but later found out he had a broken hip and hurt his left hand. The resident stated he went to the hospital and had surgery to repair his hip and left hand.

Other concerns were reported and were investigated; however, the concerns did not rise to the level of neglect.

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 was responsible for himself.

Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:

Once the facility nurse learned of the resident’s fall, the nurse assessed the resident and advised him to seek evaluation at a hospital. The resident’s primary care provider was updated.

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: 20191	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/11/2026
NAME OF PROVIDER OR SUPPLIER BURNSVILLE CAREFREE LIVING BY OXFORD			STREET ADDRESS, CITY, STATE, ZIP CODE 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 On August 11, 2026, the Minnesota Department of Health initiated an investigation of complaint #HL201912982M / #HL201911615C. No correction orders are issued.	0 000			

Minnesota Department of Health

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

TITLE

(X6) DATE