

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL201916287M
Compliance #: HL201919475C

Date Concluded: December 19, 2024

Name, Address, and County of Licensee

Investigated:

Burnsville Carefree Living
600 East Nicollet Boulevard
Burnsville, MN 55337
Dakota County

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

Evaluator's Name: Christine Bluhm, 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:

The facility neglected the resident when it did not assist her to the bathroom, change her incontinence brief, or answer her call pendant.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined neglect was not substantiated. The resident's care plan included interventions when the resident is resistive to assistance. The resident also has memory issues related to timeline. It was not found that staff were refusing to provide bathing and incontinence services.

The investigator conducted interviews with facility staff. The investigation included review of the resident record, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator interviewed other residents in the facility regarding the care they receive and staff's response to call pendants.

The resident resided in an assisted living. The resident's diagnoses included spinal stenosis, chronic leg pain, bipolar disorder, and panic disorder. The resident's service plan indicated she required assistance with bathing, dressing, grooming, and medication administration. The resident was assessed to be incontinent, required a wheelchair for mobility, and assist with transfers in and out of her wheelchair. The plan also included behavior interventions for refusal of care due to embarrassment with incontinence. Caregivers were to report refusals to nursing. The plan indicated the resident was a poor historian due to memory and cognition issues.

The resident's progress notes indicated the resident would mention to outside providers that she was not given showers or incontinence care. However, the progress notes also documented refusals of showers and incontinence care offered by the facility's caregivers although the resident allowed a nurse to assist with these cares.

During interview, a nurse stated she received a call from the resident's case manager indicating the resident needed attention and had been sitting in soiled clothing since the night before. The nurse stated she went to the resident's apartment and assisted with incontinence care. The resident did not have redness or open sores. The nurse explained a possible explanation for a delay in care that day, as there was a building evacuation due to a suspected gas leak and residents had to wait outside the building for several hours. The nurse attributed the resident's incontinence possibly due to the evacuation.

The investigator confirmed from facility management there had been a building evacuation the morning this concern arose.

During interview, a case manager stated that she spoke to the resident about the importance of allowing staff to assist her with her shower as the resident would sometimes refuse when staff offered her a shower.

Another case worker was interviewed and stated that at times when she visited the resident and, if the resident was incontinent, the facility caregivers responded when the call pendant was activated and provided the resident assistance. The case worker stated there had been times the resident was confused on time claiming she had been sitting in soiled clothing since the night before, but she had been changed into her day clothes.

During interview, the resident stated there were times she would push the call button to use the restroom but by the time staff got there it was too late. The resident stated it usually takes them about ten minutes to get there.

In conclusion, the Minnesota Department of Health determined neglect was not substantiated.

Vulnerable Adult interviewed: Yes.

Family/Responsible Party interviewed: Not applicable.

Alleged Perpetrator interviewed: Not applicable.

Action taken by facility:

No action required.

Action taken by the Minnesota Department of Health:

No 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 10/22/2024
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NAME OF PROVIDER OR SUPPLIER BURNSVILLE CAREFREE LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 600 EAST NICOLLET BOULEVARD BURNSVILLE, MN 55337
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(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	<p>Initial Comments</p> <p>On October 22, 2024, the Minnesota Department of Health initiated an investigation of the following complaints:</p> <p>#HL201917648C #HL201917647C/#HL201915482M. #HL201917646C/#HL201915481M. #HL201919475C/#HL201916287M.</p> <p>No correction orders are issued.</p>	0 000		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____