Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL201919982M
Compliance #: HL201919889C

Date Concluded: May 27, 2025

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:
Maerin Renee, 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 staff members did not administer the resident's clozapine (an antipsychotic medication used to lower the risk of suicidal behavior in individuals with schizophrenia or schizoaffective disorder) for four days. The resident was hospitalized for a suicide attempt.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The resident did not receive four doses of clozapine after the resident ran out of medication and staff failed to ensure nursing was aware to order more. Although a medication error occurred, the error was an isolated incident. The resident developed suicidal ideation, was hospitalized for psychiatric stabilization, and the resident returned to her baseline mental health condition.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident record, hospital records, pharmacy records, facility internal investigation, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed medication pass procedures.

The resident resided in an assisted living facility. The resident's diagnoses included schizoaffective disorder, bipolar type; borderline personality disorder; and panic disorder without agoraphobia. The resident's services included assistance with activities of daily living, behavioral support, and medication management. The resident's assessment indicated the resident's mental health diagnoses contributed to increased risk for self-abuse and would be monitored per the resident's care plan and behavioral health plan.

An incident report indicated a missing medication led to the resident's worsening mood/depression. Staff did not administer clozapine to the resident for four days, although a full card of clozapine had been available in the nursing office. Possible contributing factors were noted as failure of the nurse to follow policy and procedures and nursing's failure to keep medication in stock available to medication passers. Nursing also failed to monitor medication administration compliance.

The resident's MAR (medication administration record) indicated staff documented the resident's clozapine as "medication not available" for four days. Staff did not document any follow-up.

The resident's progress notes indicated the resident had become "heavily depressed." The resident said she was feeling bad about herself and that she would be better off dead. The resident felt unhappy and lonely and said, "I don't know how I'm going to live like this, I just want to die." The resident's PHQ-9 score was 24 (providers use the Patient Health Questionnaire-9 [PHQ-9], to screen, diagnose, monitor, and measure the severity of depression. A PHQ-9 score between 20-27 indicates "severe" depression and suggests the immediate initiation of pharmacotherapy and expedited referral to a mental health specialist).

A later progress note indicated the resident said she had a knife but threw it away. Staff searched the resident's room and trash but did not find a knife. The resident agreed to go to the hospital for further assessment. After that, nursing discovered staff had not administered clozapine to the resident for four days prior, although a full card of clozapine had been available in the nursing office. Nursing had not been aware the resident had missed her clozapine.

Hospital records indicated the resident's chief complaint was suicidal ideation. The resident reported for the past four days she had been feeling increasingly depressed and suicidal with a plan to overdose on medications. The resident had been "very suicidal" and did not feel safe. At the time of hospital discharge, after re-titrating the resident's clozapine, the resident attended groups, became social with peers, was future-oriented, and denied suicidal ideation.

When interviewed, a facility nurse said the resident's clozapine, to be taken once daily in the evening, was delivered on cards from the pharmacy. To avoid confusion from using two different cards at the same time, the nurse would wait to put the new card in the medication cart until the old card was used up. When medication passers administered the last dose of clozapine from one card, they documented in the resident's MAR that the clozapine was unavailable. Staff did not notify nursing. The nurse said after a few days, he noticed the resident developing symptoms he had not seen before and checked her MAR. The nurse discovered the resident's clozapine had been documented as unavailable for several days. Evening medication passers did not call the triage line, because they were unaware the after-hours triage line communicated with nursing. If nursing ran a report, the MAR would indicate a medication was out, but the MAR did not actively notify nursing if a medication was unavailable. The nurse said he increased MAR audits from one day to two days a week.

When interviewed, evening medication passers said when the resident's clozapine ran out, they documented in the MAR that the clozapine was unavailable. The evening medication passers said on the day shift, they would notify the nurse of any medications that had run out. But in the evening, there was no nurse on duty, and they thought the MAR documentation would automatically notify nursing that the resident's clozapine had run out. The evening medication passers were unaware the triage line communicated with nursing. They did not call the triage line because they did not know triage would pass their messages to nursing.

When interviewed, the resident said she was angry about the medication error, but since restarting the clozapine her mood had improved, and she was feeling okay.

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 is her own guardian.

Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility provided refresher training to staff on when to contact a nurse, and the facility updated medication oversight procedures for nursing.

Action taken by the Minnesota Department of Health:
The facility was found to be in noncompliance. 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

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

You may also call 651-201-4200 to receive a copy via mail or email.

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 04/21/2025

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, 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: #HL201919889C/#HL201919982M On April 21, 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 order is issued for #HL201919889C/#HL201919982M, tag identification 1760.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication	01760		

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01760	Continued From page 1 Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on interview and document review, facility staff failed to administer clozapine (an antipsychotic medication used to lower the risk of suicidal behavior in individuals with schizophrenia or schizoaffective disorder) as prescribed for one of one resident, R1, with chart reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause 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 medical record indicated the resident had diagnoses including schizoaffective disorder, bipolar type; borderline personality disorder; and panic disorder without agoraphobia.	01760		

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01760	Continued From page 2 R1's service plan, dated April 24, 2025, indicated the resident received services including assistance with activities of daily living, behavioral support, and medication management. An incident report, dated March 10, 2025, indicated a missing medication led to R1's worsening mood/depression. Staff did not administer clozapine to R1 for four days, although a full card of clozapine had been available in the nursing office. Possible contributing factors were noted as failure of the nurse to follow policy and procedures and nursing's failure to keep medication in stock available to medication passers. Nursing also failed to monitor medication administration compliance. R1's medication administration record (MAR), dated March 2025, indicated R1 was prescribed 3 tablets of 100 milligram (mg) clozapine, to be taken with 1 50mg for a total of 350mg every evening. Medication passers documented the resident's clozapine as "medication not available" for four days, between March 4, 2025-March 7, 2025. Staff did not document any follow-up. A progress note, dated March 7, 2025, indicated R1 had become "heavily depressed." R1 said she was feeling bad about herself and that she would be better off dead. R1 felt unhappy and lonely and said, "I don't know how I'm going to live like this, I just want to die." R1's PHQ-9 score was 24 (providers use the Patient Health Questionnaire-9 [PHQ-9], to screen, diagnose, monitor, and measure the severity of depression. A PHQ-9 score between 20-27 indicates "severe" depression and suggests the immediate initiation of pharmacotherapy and expedited referral to a mental health specialist).	01760		

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01760	Continued From page 3 A progress note, dated March 8, 2025, indicated R1 said she had a knife but threw it away. Staff searched R1's room and trash but did not find a knife. R1 agreed to go to the hospital for further assessment. A progress note, dated March 10, 2025, indicated nursing discovered a medication error in which staff had not administered R1's clozapine since March 4, 2025, although a full card of clozapine had been available in the nursing office. Nursing had not been aware the resident had missed her clozapine. During an interview on April 21, 2025, at 10:00 a.m., a facility nurse, (RN)-G, said R1's clozapine was delivered on cards from the pharmacy. To avoid confusion from using two different cards at the same time, RN-G would wait to put the new card in the medication cart until the old card was used up. When medication passers administered the last dose of clozapine from one card, they documented in R1's MAR that the clozapine was unavailable. Staff did not notify nursing. RN-G said after a few days, he noticed R1 developing symptoms he had not seen before and checked her MAR. RN-G discovered R1's clozapine had been documented as unavailable for several days. Evening medication passers told RN-G they did not have anyone to report the unavailable clozapine to. Evening medication passers did not call the triage line, because they were unaware the after-hours triage line communicated with nursing. If nursing ran a report, the MAR would indicate a medication was out, but the MAR did not actively notify nursing if a medication was unavailable. RN-G said he increased MAR audits from one day to two days a week.	01760		

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01760	Continued From page 4 During an interview on April 23, 2025, at 11:00 a.m., an unlicensed personnel (ULP)-F said when medication passers document in a resident's MAR that a medication in unavailable, a nurse is supposed to see it and restock the medication. During an interview on April 25, 2025, at 9:30 a.m., an unlicensed personnel (ULP)-E said after R1's clozapine ran out, he documented it on the MAR and thought nursing would automatically be notified by the MAR that the clozapine needed to be refilled. ULP-E said during the day shift when a nurse is on site, medication passers would notify a nurse if a medication is out of stock. ULP-E said on the evening shift there was no one to report to. The facility's policy titled When to Call the Nurse, suggested First Aid and Emergency Guidelines, dated January 16, 2023, indicated staff were to contact a nurse any time there was a question regarding a medication or treatment order, including medication setup, administration, medication not available, medication error or resident refusal. TIME PERIOD FOR CORRECTION: Seven (7) days.	01760		