Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL304453042M
Compliance #: HL304455312C

Date Concluded: July 17, 2025

Name, Address, and County of Licensee Investigated:
The Lodge on Summit Oaks
1412 Summit Oaks Drive
Burnsville, MN 55337
Dakota County

Facility Type: Assisted Living Facility (ALF)

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 a resident when they failed to ensure the facility staffed onsite licensed nursing 24 hours seven days a week to perform as needed tracheostomy suctioning (surgical opening in the neck with a tube inserted to provide an airway and to remove secretions from the lungs) for the resident. Unlicensed staff were directed to call 911 if the resident required suctioning when a nurse was not at the facility.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although the facility did not staff onsite nursing 24 hours a day, the facility had a plan in place in case the resident required suctioning if a nurse was not available. The resident developed no complications from the facility's plan.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The resident's family member was interviewed. The

investigation included review of the resident record, death record, personnel files, staff schedules, state nursing surveyor's documents, and related facility policy and procedures. Also, the investigator observed staff and residents and staff interactions during her onsite investigation.

The resident resided in an assisted living facility. The resident's diagnoses included Stage IV head and neck cancer, squamous cell carcinoma (skin cancer) and tracheostomy placement. The resident's care plan included assistance with personal cares, medications, and as needed stand-by assistance with transfers, and walking. The resident's assessment indicated the resident was alert and oriented and made his own decisions.

In a communication note sent by the resident's provider to the facility, the provider indicated the resident did not require 24 hours a day seven days a week onsite nursing staff. The provider indicated the facility was the resident's long-term home, indicating the resident had done well with the resident's care plan developed by the facility.

When interviewed, a licensed staff person stated the resident was completely independent with suctioning his tracheostomy and did not require nurse assistance until the last few months, stating even then nurses only suctioned him a handful of times.

When interviewed, a licensed staff member stated the resident was "quite sweet" and appreciated everything staff did for him, stating he loved living at the facility.

When interviewed, the resident's family member stated the resident was pleased with the care provided by facility staff.

In conclusion, the Minnesota Department of Health determined 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: No, the resident was deceased at the time of the onsite investigation.

Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not applicable.

Action taken by facility:
The facility transferred the resident to a sister facility that provided 24 hour onsite nursing.

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
	30445	A. BUILDING: _____ B. WING _____	C 06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LODGE ON SUMMIT OAKS	1412 SUMMIT OAKS DRIVE 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 June 26, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL304455312C/#HL304453042M, and #HL304456090C. No correction orders were issued.	0 000		