

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** HL304459605M  
**Compliance #:** HL304457523C

**Date Concluded:** June 6, 2024

## **Name, Address, and County of Licensee**

### **Investigated:**

The Lodges Company  
1412 Summit Oaks Drive  
Burnsville, MN 55337  
Dakota County

**Facility Type:** Assisted Living Facility (ALF)

**Evaluator's Name:** James P. Larson, RN  
Special Investigator

**Finding:** Inconclusive

## **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 they failed to provide care in accordance with the resident's service plan.

## **Investigative Findings and Conclusion:**

The Minnesota Department of Health determined neglect was inconclusive. It is unable to be determined if the actions or inactions of facility staff contributed to the resident's wound healing or appearance of new open areas.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted the resident's wound care provider. The investigation included review of the resident's medical records, employee training, facility documentation, staffing plans, schedules, and policies and procedures. Also, the investigator toured the facility and observed staff to resident interactions.

The resident resided in an assisted living facility. The resident's diagnoses include quadriplegia, morbid obesity, diabetes, and chronic pressure ulcers. The resident's service plan included assistance with all activities daily living, medications, meals, housekeeping, and transfer and repositioning assistance.

Complaint documents indicated the facility had a staffing shortage which resulted in the resident not receiving wound care as ordered.

A review of facility documents indicated that in the weeks prior to the concerns being reported, the resident received wound care as ordered and had not declined services. Detailed care notes indicated new areas of concern were reported by staff and outlined coordination of care with wound care orders and obtaining specialized durable medical equipment (DME) to aid in wound healing.

During an interview with a physician's assistant who had treated the resident for chronic pressure wounds over the previous few years, she stated that the resident would often experience fluctuating episodes of improved wound healing and wound progression. The physician's assistant attributed this was due to cognitive ability, physical stature, and possible noncompliance with the prescribed care plan.

During an interview, a staff member who coordinated personnel scheduling, stated that at no time was a shortage of personnel brought to her attention. A staffing matrix was used in correlation with input from nursing, the executive director, and operations manager. A float pool and an outside agency staffing company were also available if needed.

During an interview, a nurse stated that the resident often inquired about who and when their next care(s) would be provided. The nurse also stated that the resident was typically engaged and cooperative during his wound cares, but on occasion declined to be repositioned.

During an interview with a facility administrator, they stated that it was not reported to them by staff, or the resident, of any concern of the resident declining cares. The administrator stated that the resident requested for specific staff to perform care and that in the weeks prior to the resident relocating to another facility, he requested for only a nurse to complete daily wound care.

Attempts to contact the resident were unsuccessful.

In conclusion, the Minnesota Department of Health determined abuse was inconclusive.

**Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.**

"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or 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:** No, attempts to contact were not successful.

**Family/Responsible Party interviewed:** No, attempts to contact were not successful

**Alleged Perpetrator interviewed:** Not Applicable.

**Action taken by facility:** The facility educated the resident on the service plan and possible complications if care was declined.

**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.

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:  <b>30445</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/11/2024</b>
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NAME OF PROVIDER OR SUPPLIER  <b>THE LODGE ON SUMMIT OAKS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1412 SUMMIT OAKS DRIVE BURNSVILLE, MN 55337</b>
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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><b>Initial Comments</b></p> <p>*****ATTENTION*****</p> <p><b>ASSISTED LIVING PROVIDER CORRECTION ORDER</b></p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation.</p> <p>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.</p> <p><b>INITIAL COMMENTS:</b></p> <p><b>#HL304457523C/#HL304459605M</b></p> <p>On April 11, 2024, 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 eleven residents receiving services under the provider's Assisted Living license.</p> <p>The following correction order is issued/orders are issued for <b>#HL304457523C/#HL304459605M</b>, tag identification 0495, 0720, and 2310.</p>	0 000	<p>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.</p> <p><b>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.</b></p> <p><b>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</b></p> <p><b>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.</b></p>	
0 495 SS=F	<p><b>144G.41 Subd. 1 (14) Minimum Requirements</b></p> <p><b>(14) provide staff access to an on-call registered</b></p>	0 495		

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

Minnesota Department of Health

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0 495	<p>Continued From page 1</p> <p>nurse 24 hours per day, seven days per week</p> <p>This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to ensure a registered nurse was available 24 hours a day, seven days a week to provide consultation to staff performing delegated nursing tasks and services. This had the potential to affect all eleven residents receiving assisted living services.</p> <p>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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>On April 11, 2024, during an interview at 11:00 a.m. licensed practical nurse (LPN)-B stated that she was required to carry the facility cell phone and be on call opposite of the registered nurse.</p> <p>On April 17, 2024, ULP-D who coordinates staff scheduling for the facility stated during an interview that LPN-B was scheduled to be on-call approximately fifty percent of the time.</p> <p>On April 17, 2024 at 2:00 p.m. RN-A was interviewed and verified LPN-B was on call every other weekend, but the LPN-B could contact the RN if needed.</p> <p>The licensee's policy, 6.12 Availability of an RN for Staff policy dated August 1, 2021, indicated in</p>	0 495		

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0 495	Continued From page 2  accordance with 144G.62 Subd. 1 will have a registered nurse available for consultation by staff performing delegated nursing tasks and must have an appropriate licensed health professional available if performing other delegated services such as therapies. The RN must be readily available either in person, by telephone, or by other means to the staff at times when the staff is providing services.  TIME PERIOD FOR CORRECTION: Seven (7) days	0 495		
0 720 SS=F	144G.43 Subd. 2 Access to records  The facility must ensure that the appropriate records are readily available to employees and contractors authorized to access the records. Resident records must be maintained in a manner that allows for timely access, printing, or transmission of the records. The records must be made readily available to the commissioner upon request.  This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure appropriate records were available for timely access to the department for one of one resident (R1) with records requested to complete a complaint investigation.  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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	0 720		

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0 720	<p>Continued From page 3</p> <p>or has the potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>On April 11, 2024, at 10:45 AM during an onsite visit, the investigator discussed with facility administrator (AD)- A record requests would be sent via email to the facility. AD-A informed the investigator that her email would be sufficient and that she would work with other staff to complete the request.</p> <p>On April 11, 2024, at 10:50 AM an email message was sent to AD-A which requested the following, but was not limited to these documents, be made available. Current Staff Roster Current Resident Roster Resident Discharge Roster 2024 Employee Separation Roster 2024 Staffing Plan 2023 Staffing Plan 2024</p> <p>Other documents also included in the request included for employee information for unlicensed personnel (ULP)-D, facility policies, and requested job descriptions. Instruction for meeting timelines of the request were discussed with AD-A. No records were received on April 11, 2024.</p> <p>On April 12, 2024 at 8:50 am a call was placed to AD-D in which she asked for an extension due to limited access and schedule. AD-A agreed to submit what she had available and was not able to complete the entire request at that time. The investigator agreed to extend the timeline and explained that these requests are typically completed in hours from request. No records</p>	0 720		

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0 720	<p>Continued From page 4</p> <p>were received on April 12, 2024.</p> <p>The licensee's Request for Records Policy dated August 1, 2021, indicated [licensee] will comply with written requests for copies of records or a summary of the information in the records unless such information is detrimental to the resident's physical or mental health or would cause him or her to harm himself or herself or another. The policy lacked verbiage when dealing with the commissioner's agents.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Two (2) days</p>	0 720		
02310 SS=F	<p>144G.91 Subd. 4 (a) Appropriate care and services</p> <p>(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 service plan subject to accepted health care standards.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, and interview, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for storage of oxygen. This had the potential to affect all eleven residents.</p> <p>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) and was issued at a widespread scope (when problems are pervasive</p>	02310		

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02310	<p>Continued From page 5</p> <p>or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>On April 11, 2024, at 10:30 am, during a tour of the facility, four unsecured oxygen cylinders were observed. One lying on the floor, one standing upright on top of a three drawer file cabinet, and two more cylinders standing upright on the floor in the lower-level common area.</p> <p>Administrator (AD)-A stated that she was not sure how the oxygen cylinders should be stored.</p> <p>The licensee's policy Medication 6.9 Oxygen, dated February 6, 2024, indicated: Oxygen tanks/cylinders not in use by residents should be stored in a dedicated room, in an upright position, and secured to prevent them from falling over. Oxygen cylinders and vessels must remain upright at all times. Never tip an oxygen cylinder or vessel on its side or try to roll it to a new location. Cylinders must be secured in a carrier or in some other way (e.g. chained to wall) to prevent falling over.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>	02310		