Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL361472742M
Compliance #: HL361474847C

Date Concluded: November 5, 2025

Name, Address, and County of Licensee Investigated:
Derman Senior Care – Burnsville
2401 Williams Drive
Burnsville, MN 55337
Dakota County

Facility Type: Assisted Living Facility (ALF)

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: It is alleged the facility neglected the resident when it did not provide care and supervision to maintain the resident's health such as care for a foot wound, and medications which were set up incorrectly in the medication planner.

Investigative Findings and Conclusion: The Minnesota Department of Health determined neglect was not substantiated. There are conflicting accounts of the resident's and the facility's version of the care. The resident declined to attend scheduled doctor appointments and multiple dialysis sessions, refused multiple days of wound care offered by caregivers and one time left the hospital against medical advice. The facility documented attempts with care and the resident's refusals. There were no reported medication errors or incidents to review.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the case worker. The investigation included review of the resident record, facility incident reports, staff schedules, related facility policy and procedures. Also, the investigator observed resident and staff

interactions during a visit to the facility. The resident's hospital and dialysis visit records were reviewed.

The resident resided in an assisted living facility. The resident's diagnoses included diabetes, chronic kidney disease and Charcot Foot (a rare complication of diabetes-related neuropathy). The resident's service plan included assistance with medication management, laundry, housekeeping and transportation. The resident's assessment indicated he was his own decision maker and able to make his needs known.

A concern arose that the resident had injured his foot while riding his bicycle. He was hospitalized some days later with the recommendation to have a toe amputated but the resident left the hospital against medical advice and returned to the facility. An additional concern was that the resident was scheduled to have dialysis three times a week but missed sessions due to becoming disinterested in continuing medical care altogether because the facility did not provide the care he needed.

Progress notes indicated the facility nurse was alerted by an unlicensed caregiver regarding the resident's injured foot and the nurse made a visit to assess the injury. The resident initially refused to unwrap the foot and allow the nurse to look at it but did allow her to do so the next day. The note indicated the right foot middle toe was missing layers of skin and the wound bed was red and bruised. The nurse applied bacitracin, a fresh bandage and wrapped it in kerlix. The note concluded that the dressing should be changed daily or if soiled and the resident could manage to change it on his own if needed. The following week, the resident allowed the nurse to assess the foot wound and apply a fresh bandage. The nurse documented that the wound was open with no redness, swelling or signs of infection. At the next couple of nurse visits, the resident refused to have the nurse look at the wound. The resident's dialysis team called the nurse and asked if a doctor had evaluated the wound. The nurse called the resident's doctor and set up an appointment to be seen but the resident refused to go to the appointment when the day arrived. The notes indicated the resident was hospitalized and given recommendation for toe amputation and the resident declined the option at that time.

During an interview, the nurse stated the resident refused some of her attempts to look at the wound and she documented the refusals. Sometimes he wanted to do the dressing changes himself and was capable of doing so. She stated the wound got worse and the toe had to be amputated. She said one time he left the hospital against medical advice and returned to the facility; upset with staff that they allowed him to return with an intravenous access (IV) in his arm. The nurse stated the resident also complained that he did not receive the correct medications but could not specify which medications had been set up incorrectly. In response, she had him verify the medications with her each time she set them up in his med planner.

During an interview, a facility supervisor stated the resident had been going through a difficult time and loss when he lived at the facility. He would refuse care for his diabetes that included dialysis. The supervisor stated facility staff are trained to talk through issues and find out why

residents refuse and remind them of the importance to complete care. As for the wound, the resident at first refused anyone to look at it and was sent to the hospital when he could not walk on it. There were times when the resident would want to do the dressing changes himself. As for the medications, since the resident had concerns, they had the nurse show him each medication from the labeled bottle while she set them up in the planner. There were no reported medication errors.

During interview, a facility manager stated staff tried to meet the resident's needs and tried to be understanding with him. For example, if it was his dialysis day, they always made sure transportation was available for him. The manager stated the resident moved to a higher level of care facility to meet his needs.

During interview, the resident stated the facility was not able to meet for his care needs and he is now living somewhere with more nursing care.

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: Not Applicable.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility: The nurse increased visits to assist with wound care.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36147	A. BUILDING: _____ B. WING _____	C 09/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DERMAN SENIOR CARE INC	2401 WILLIAMS DR 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 September 3, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL361474847C/#HL361472742M. No correction orders are issued.	0 000		