Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL384122762M
Compliance #: HL384124937C

Date Concluded: July 16, 2025

Name, Address, and County of Licensee Investigated:

Suite Living Senior Care
1880 134th Street East,
Burnsville, MN 55337
Dakota County

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

Evaluator's Name: Brandon Martfeld, RN, BSN, 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 alleged perpetrator (AP), a facility staff member neglected the resident when the AP failed to follow the resident's plan of care, and the resident sustained a left fractured tibia (the primary weight-bearing bone in the lower leg) and fibula (the smaller of the two bones in the lower leg).

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although the AP did not follow the resident's plan of care of placing foot pedals on the resident's wheelchair, the error was an isolated incident. The resident sustained a fractured tibia, was hospitalized for two days, and returned to the resident's baseline 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 records,

hospital records, facility internal investigation, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed staff and resident interactions.

The resident resided in an assisted living facility. The resident's diagnoses included a previous fractured left femur (thigh bone). The resident's service plan included assistance with dressing, toileting, and two staff for transfers with a mechanical lift. The resident's assessment indicated the resident was forgetful but cognitively intact and required a wheelchair for mobility.

Review of a facility recorded camera footage showed the AP as she pushed the resident out of a room and down a hallway. The resident lifted her feet of the ground without foot pedals as they proceeded down the carpeted hallway. After a few seconds of moving forward, the resident's left foot caught on the carpet causing the left leg to bend under the wheelchair and a cracking noise could be heard. The resident yelled out and grabbed her left knee. The resident said, "oh my gosh, did you hear that." The staff member bent down next to the resident and said, "what was that and the resident replied, "that was my knee." The resident stated, "I don't have my feet (foot pedals) on my chair." The staff member stood and walked back to the resident's apartment.

The incident report indicated the staff member assisted the resident to the nurse's office following the incident. The resident was assessed by the nurse and was sent to the hospital for an evaluation.

The hospital records indicated the resident fractured her left tibia (shin bone) and was hospitalized for two days. The resident required a knee immobilizer and was two days later was discharged back to the facility.

During an interview, the AP stated she usually worked overnight shifts, and had worked the previous overnight shift and into the day shift. The AP stated around lunch time, the resident called for assistance, appeared anxious, and stated she wanted to go to the nurse's office because she had questions about a doctor appointment. The resident was in her wheelchair and was just inside the doorway of her apartment. The AP stated she assisted the resident out of her apartment and down the hallway. The AP stated they did not get very far down the hallway when a cracking noise was heard. The AP stated she stopped immediately and checked on the resident. The resident was screaming in pain. The AP stated the resident's foot pedals were put on her wheelchair immediately after the cracking noise was heard. The AP stated she wheeled the resident to the nurse's office, explained to the nurse what had happened, and the resident was sent to the hospital.

During an interview nursing leadership stated the AP brought the resident to the nursing office and the resident was assessed. The resident could not move her left leg and was sent to the hospital for an evaluation. Leadership stated after the incident, all staff including the AP were trained to apply foot pedals when escorting residents in their wheelchairs.

During an interview, a family member stated the resident moved into the facility due to needing assistance because of a fractured left femur and that the resident had osteoporosis (a disease that weakens bones, making them more fragile and susceptible to fractures).

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: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
Following the incident, the resident was assessed and transported to the hospital for evaluation. In addition, the facility and the AP were educated on resident’s that required foot pedals.

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
	38412	A. BUILDING: _____ B. WING _____	C 07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUITE LIVING SENIOR CARE OF BURNSVILLE	1880 134TH STREET EAST 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 July 2, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL384122762M/#HL384124937C. No correction orders are issued.	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.	