Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL201911982M
Compliance #: HL201913367C

Date Concluded: June 6, 2025

Name, Address, and County of Licensee Investigated:
Burnsville Carefree Living
600 E. Nicollet Ave.
Burnsville, MN 55337
Dakota County

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

Evaluator's Name: Michele Larson, RN
Special Investigator

Finding: Substantiated, facility responsibility

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 ensure the resident received care, services, and supervision according to the resident's plan of care. The resident fell and fractured (broke) her left arm while attempting to toilet herself.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. At the time of the fall, facility staff failed to ensure the resident had a means to summon staff when the resident required assistance with transferring and toileting. The resident was required to holler for staff when needing assistance.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The resident was interviewed. The investigator contacted the resident's legal guardian. The investigation included review of the resident's facility record, hospital record, orthopedic record, facility fall incident reports, personnel files, staff schedules,

and related facility policy and procedures Also, the investigator observed direct cares with the resident and facility staff.

The resident resided in the facility's assisted living memory care unit. The resident's diagnoses included unspecified intracranial injury with loss of consciousness (damage to the brain inside the skull and inability to be aware of oneself and surroundings), muscle weakness, epilepsy, unsteadiness of feet, and repeated falls. The resident's service plan included assistance with transfers and toileting, and hourly safety checks to help prevent frequent falls. The resident's fall assessment score indicated she was at risk for falls. The resident was able to make her needs known and be understood, but her cognition was moderately impaired. The resident used a wheelchair and a walker for mobility.

During the resident's hourly safety checks, staff were directed to ensure the resident's call pendant worked and the resident wore it. If the call pendant was not worn by the resident, staff were to help locate the pendant, re-educate the resident on the benefits of wearing it, or notify a supervisor immediately if the pendant was not working.

The resident's fall incident report indicated on the 1st day of a month at 8:30 p.m., staff found the resident naked on her bathroom floor. The resident's wheelchair was positioned near the bathroom door. The resident told staff she wanted to take a shower. Two staff assisted the resident off the floor after no apparent injuries noted. No vitals were obtained by staff. The incident report lacked evidence the resident had her call pendant available to call for staff assistance.

A fall incident report indicated on the 8th day of the same month, at 3:45 a.m., staff found the resident on the bathroom floor in front of her toilet. The resident told staff she missed the toilet seat and fell. The resident reported pain. Staff observed the resident's legs and right arm were swollen. At 4:20 a.m., staff arranged for the resident to be transported to a hospital for an evaluation. The incident report lacked evidence the resident had her call pendant available to call for staff assistance.

Review of the hospital record indicated the resident reported she fell while trying to get out of bed. The resident complained of neck, stomach, left arm, ankle, and back pain. The resident rated her pain severe (7/10) with 10 being the worst pain. Images (x-rays) obtained indicated the resident suffered an acute fracture of a left lower forearm bone (radius) as well as a chronic fracture of the left upper forearm bone (humerus) near the elbow. The resident's left arm was placed in a sling with instructions to avoid heavy weight bearing until her follow-up appointment with orthopedic surgery. The resident was prescribed a strong narcotic pain medication (hydrocodone) before being discharged back to the facility.

The resident's outpatient orthopedic record dated three days later indicated during her follow-up evaluation the resident reported pain in her left ankle. X-rays indicated the resident also broke a left lower leg bone (fibula) near her left ankle. The resident was required to wear a

fracture (walking) boot for four weeks with weight bearing as tolerated and her wheelchair for long distances.

The services delivered record during the timeframe of the resident's fall indicated staff checked the functioning and location of the resident's call pendent every hour.

When interviewed, facility staff stated the resident knew how to use a call pendant to summon staff.

During an interview, leadership stated the facility used call pendants for their residents to request assistance from staff. Leadership stated staff had not reported the resident's call pendant was missing. Leadership stated after the investigator left the facility, they were not able to locate the resident's call pendant and staff immediately provided a call pendant to the resident and ensured it worked properly.

When interviewed, the resident's legal guardian stated the resident misplaced items frequently and stated staff were supposed to make sure the resident either wore her call pendant or it was on her wheelchair.

When interviewed, the resident stated prior to her fall the facility did not have a call system on her, stating she "hollered" for staff assistance. The resident stated she did not recall how long she was without her call pendant but thought it was a week. The resident stated at times it took staff a while to respond to her yelling, stating she sometimes urinated on the floor because she had to wait for staff. The resident stated since the fracture she still had pain in her left arm and was unable to sleep on her left side.

In conclusion, the Minnesota Department of Health determined neglect was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

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: Not Applicable.

Action taken by facility:
The facility replaced the resident's missing call pendant.

Action taken by the Minnesota Department of Health:
The responsible party will be notified of their right to appeal the maltreatment finding.

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
Dakota County Attorney
Burnsville City Attorney
Burnsville Police Department

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 05/13/2025

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, this correction order is 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: #HL201913767C/#HL201912143M #HL201913367C/#HL201911982M On May 13, 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 orders are issued for #HL201913367C/#HL201911982M, tag identification 2310 and 2360.	0 000		
02310 SS=G	144G.91 Subd. 4 (a) Appropriate care and services (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	02310		

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02310	Continued From page 1 service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide care and services according to acceptable health care, medical or nursing standards for one of one resident (R1) with record reviewed for falls. R1 fell and fractured her left forearm and left lower leg bone (fibula) while attempting to toilet herself. The facility failed to provide R1 with a means to contact staff for assistance when she fell. R1 was transported to the hospital to receive treatment for her fractured arm. In addition, the licensee failed to ensure R1 was assessed by a facility registered nurse (RN)-D after R1 was discharged from the hospital after fracturing her arm. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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 record was reviewed. R1 was admitted to the licensee's facility on July 30, 2024. R1's diagnoses included but were not limited to unspecified intracranial injury with loss of consciousness (damage to the brain inside the skull and inability to be aware of oneself and surroundings), muscle weakness, epilepsy (seizures), unsteadiness of feet, and repeated	02310		

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02310	Continued From page 2 falls. R1 used a walker and wheelchair for mobility. R1's service plan dated July 30, 2024, indicated R1 received assistance with personal cares, medication, meals, transfers and toileting. In addition, R1 was supposed to receive hourly safety checks to help prevent frequent falls. During the hourly checks staff were to ensure R1's call pendant worked and R1 wore the call pendant. If R1 was not wearing her call pendant staff were to help locate her pendant, re-educate R1 on the benefits of wearing the pendant, or notify a supervisor immediately if her call pendant was not working. R1's assessment dated February 6, 2025, indicated R1 was able to make her needs known and be understood, but her cognition was moderately impaired. R1's fall assessment score indicated she was at risk for falls. R1's fall incident report dated March 8, 2025, at 8:12 a.m., indicated R1 fell in the bathroom while transferring herself from her wheelchair to the toilet. Vitals were obtained. No injuries were observed and R1 reported no pain. Staff reported R1 used her call pendant to request staff assistance. R1's progress note dated March 26, 2025, at 1:48 p.m., indicated R1 said she slipped and fell in her bathroom then dragged herself into the main area of her apartment where she was found by staff. Staff lifted R1 back into her wheelchair. Staff educated R1 about having staff present while performing personal cares. R1 verbalized understanding. No vitals were obtained. Staff did not document if R1 did or did not sustain injuries from her fall. R1's record lacked evidence her call	02310		

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02310	Continued From page 3 pendant was available to her to call staff for assistance. R1's fall incident report dated April 1, 2025, at 8:30 p.m., indicated staff found R1's wheelchair near her bathroom door and R1 naked on the bathroom floor. R1 told staff she wanted to take a shower. Two staff assisted R1 off the floor after no apparent injuries noted. R1's vitals were not obtained. R1's fall incident report lacked evidence R1 had her call pendant available to call staff for assistance. Another fall incident report dated April 8, 2025, at 3:45 a.m., indicated staff found R1 on the bathroom floor in front of her toilet. R1 told staff she missed the toilet seat and fell. R1 reported pain. Staff observed R1's legs and right arm were swollen. At 4:20 a.m., emergency medical services (EMS) arrived and transported R1 to the hospital emergency department (ED). The incident report lacked evidence R1 had her call pendant available to call for staff assistance. R1's ED record dated April 8, 2025, at 4:53 a.m., indicated R1 suffered a fall while trying to get out of bed. R1 complained of neck, abdominal, back, and left arm and ankle pain and rated her pain severe (7/10). Images (x-rays) obtained indicated R1 suffered an acute fracture of a left lower forearm bone (radius) as well as a chronic fracture of the left upper forearm bone (humerus) near the elbow. R1's left arm was placed in a sling with instructions to avoid heavy weight bearing until her follow-up appointment with orthopedic surgery. R1 was prescribed a strong narcotic pain medication (hydrocodone) before being discharged back to the facility. R1's record lacked evidence R1 was reassessed	02310		

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02310	Continued From page 4 by RN-D upon her return to the facility. R1's orthopedic outpatient record dated April 11, 2025, at 12:39 p.m., indicated during R1's follow-up evaluation, R1 reported pain in her left ankle. X-rays indicated R1 also broke a left lower leg bone (fibula) near her left ankle. R1 was required to wear a fracture (walking) boot for four weeks with weight bearing as tolerated and her wheelchair for long distances. During in interview on May 13, 2025 at 2:45 p.m., R1 stated the facility did not have a call system for her prior to her fall, stating she "hollered" for staff assistance if she needed them. R1 stated she did not recall how long she was without her call pendant but thought it was a week. R1 stated at times it took staff a while to respond to her yelling, stating she sometimes urinated on the floor because she had to wait for staff. R1 stated since the fracture she still had pain in her left arm and was unable to sleep on her left side. On May 13, 2025, at 3:30 p.m., the investigator requested R1's call pendant report for a two-week time frame surrounding R1's fall from April 1, 2025-April 15, 2025. In addition, the investigator requested RN-D to check if R1 had a call pendant. During an interview on May 14, 2025, at 9:00 a.m., licensed practical nurse (LPN)-B stated R1 knew how to use her call pendant and to call for help. During an interview on May 14, 2025, at 11:35 a.m., R1's legal guardian (LG)-C stated R1 misplaced items frequently. LG-C stated staff were supposed to make sure R1's pendant was either on her or her wheelchair.	02310		

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02310	Continued From page 5 In an email dated May 19, 2025, at 1:40 p.m., from RN-D to the investigator, RN-D attached R1's requested call pendant report for the two-week time frame surrounding her fall. Review of R1's call pendant report indicated R1 never used her call pendant within the two-week time frame. In a follow-up phone call dated May 20, 2025, at 12:26 p.m., RN-D stated R1 did not have a call pendant but stated they immediately provided a pendant to R1 after the investigator left the facility. In an email from the investigator to RN-D dated May 29, 2025, at 6:48 a.m., the investigator requested a second call pendant report dated May 14, 2025 through May 28, 2025, the day after R1 received a call pendant from the facility. On May 29, 2025, at 10:39 a.m., the investigator received R1's second call pendant report. Review of R1's second report indicated R1 used her call pendant several times to request staff assistance during different times of the day. During an interview on May 29, 2025, at 11:23 a.m., RN-D confirmed she did not reassess R1 and was unaware it was in the Minnesota Assisted Living 144G statutes that ongoing resident reassessment and monitoring must be conducted based on a change in the a residents condition. The licensee's policy titled Assessments, Reviews, and Monitoring, updated January 16, 2023, indicated resident monitoring and review must be conducted as needed based on changes in the needs of the resident and were not to	02310		

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02310	Continued From page 6 exceed 90 calendar days from the date of the last review. Review of current plan of care, and if needed a reassessment would be done following a change in condition including but not limited to falls. TIME PERIOD FOR CORRECTION: Seven (7) days.	02310		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident(s) reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		