STATE LICENSING COMPLIANCE REPORT

Report #: HL201912712C

Date Concluded: May 27,2025

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

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

Evaluator's Name: Michele Larson, RN

The Minnesota Department of Health conducted a complaint investigation to determine compliance with state laws and rules governing the provision of care under Minnesota Statutes, Chapter 144G. The purpose of this complaint investigation was to review if facility policies and practices comply with applicable laws and rules. No maltreatment under Minnesota Statutes, Chapter 626 was alleged.

To view a copy of the correction orders, if any, please visit: https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html, or call 651-201-4201 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached state form.

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 04/25/2025

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: #HL201912712C On April 25, 2025, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction order is 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 order is issued for #HL201912712C, tag identification 2130.	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.	
02130 SS=E	144G.83 Subd. 2 Staffing requirements (a) The licensee must ensure that staff who	02130		

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02130	Continued From page 1 provide support to residents with dementia can demonstrate a basic understanding and ability to apply dementia training to the residents' emotional and unique health care needs using person-centered planning delivery. Direct care dementia-trained staff and other staff must be trained on the topics identified during the expedited rulemaking process. These requirements are in addition to the licensing requirements for training. (b) Failure to comply with paragraph (a) or subdivision 1 shall result in a fine under section 144G.31. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the licensee's facility applied person-centered planning delivery for one of one resident (R1) with record reviewed. The licensee's facility failed to have adequate resources and means to assist larger-sized residents off the floor when they fell. Facility staff were unable to assist R1 off the floor when she experienced a fall with no injuries due to R1's physical size. Instead, the facility instructed staff to call 911 for lift assist, potentially leaving the fire department short-handed to respond to critical emergencies. 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, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).	02130		

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02130	Continued From page 2 The findings include: The licensee's Uniform Disclosure of Assisted Living Services & Amenities (UDALSA), dated November 28, 2023, and posted on the Minnesota Department of Health's (MDH) website (https://www.health.state.mn.us), indicated the licensee's facility offered a mechanical lift with the assist of two staff persons for transfers. On April 25, 2025, at 10:00 a.m. the MDH investigator entered the facility. During the entrance conference at 11:10 a.m., assistant assisted living director (ALALD)-B stated the facility did not have any mechanical lifts (Hoyer) because they were licensed as an assisted living facility, stating Hoyer lifts were for facilities with residents who required a higher level of care. ALALD-B stated there were a few residents who fell but stated R1 frequently fell and would call the fire department herself to assist R1 off the floor. R1's medical record was reviewed. R1 was admitted to the licensee's facility on June 19, 2024. R1's diagnoses included but were not limited to morbid obesity, chronic joint pain (osteoarthritis), major depressive disorder, Bipolar disorder, and Post-Traumatic Stress Disorder (PTSD). The resident used a manual wheelchair and a four wheeled walker for mobility. R1's assessment dated January 17, 2025, indicated R1 was alert and oriented to person, place, time, and situation. R1 was independent with walking and bed mobility but required stand-by assistance with transfers. R1's Individual Abuse Prevention Plan (IAPP) dated March 27, 2025, indicated R1 was unable	02130		

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02130	Continued From page 3 to ambulate safely with or without a mobility device. Staff were to keep R1's apartment free of clutter and hazards to ensure R1 remained free from falls. R1 had chronic pain and required regular follow-up visits with her medical provider regarding her chronic conditions and took her prescribed medications as directed. R1's service plan dated April 30, 2025, indicated R1 received assistance with personal cares, medication administration, and three daily safety checks. Review of R1's fall incident reports dated Between February 24, 2025, and May 15, 2025, indicated the fire department responded to 17 calls to R1's apartment for lift assist. Several of R1's incident reports indicated under the title "What did you do? Describe all the assistance given," indicated staff were advised to call 911 for lift assist to help R1 off the floor when she fell. During an interview on April 21, 2025, at 3:24 p.m., assistant fire chief, (AFC)-A stated between January 1, 2025 and April 21, 2025, the fire department received many calls to assist R1 off the floor, stating he believed R1 required a higher level of care than the facility could provide in addition to a Hoyer lift. During interviews on April 25, 2025, with several unlicensed staff, many reported they were unable to manually lift R1 off the floor due to her size. During an interview on April 25, 2025, at 11:05 a.m., registered nurse (RN)-C stated the licensee's facility was not licensed to have Hoyer lifts at the facility. During an interview on April 25, 2025, at 1:40 p.m., R1 stated, there was no one at the facility	02130		

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02130	Continued From page 4 who could lift her because she "weighed too much." R1 stated one male unlicensed personnel (ULP) was able to lift her off the floor but stated, "I was worried he tweaked his back." R1 stated she called 911 for lift assist because she did not want staff to attempt to lift her off the floor. In a follow-up interview on May 12, 2025, at 10:59 a.m., AFC-A stated the fire department had not seen a reduction in lift assist calls for R1, stating they received six additional calls for lift assist between April 25, 2025 and May 12, 2025. AFC-A expressed frustration stating responding to the facility's lift assist calls took away the possibility of helping someone in need. The licensee protocol titled Guidelines for Transfers dated June 24, 2021, indicated when residents were alert, relatively strong, agile, or arthritic, stiff, anxious, and uninjured, staff were to manually assist the residents off the floor. Under the title "Too Heavy to Do That," staff were call 911 as the licensee's facility did not use lifts anymore. TIME PERIOD TO CORRECT: Twenty-one (21) days.	02130		