Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL201919482M
Compliance #: HL201918661C

Date Concluded: May 22, 2025

Name, Address, and County of Licensee 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
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 facility neglected a resident when they failed to administer the resident's medications or provide meals for five days, causing the resident to miss his dialysis treatment (a process of removing waste and excess fluid from blood that kidneys would normally remove). In addition, the facility financially exploited the resident when they stole money from his bank account causing the resident to be fearful and afraid for his life.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Documentation in the resident's record indicated staff administered the resident's medications and provided services during the five days prior to the resident's hospitalization. The resident was responsible for scheduling his dialysis appointments and medical transportation and frequently missed his appointments telling facility staff he did not want to go. After missing three dialysis appointments in a row the resident was hospitalized with uremic toxicity (the buildup of harmful waste products in the bloodstream due to failing kidneys).

The Minnesota Department of Health determined financial exploitation was not substantiated. The discrepancy in the resident's money was reconciled by facility leadership and the resident's case manager. It was determined there the resident's funding from social security and supplemental income decreased. The resident was satisfied when the facility explained why his funding decreased.

The investigator conducted interviews with facility staff members, including facility leadership, nursing staff, and unlicensed staff. The investigator contacted the resident's case worker. The investigation included review of the resident's facility record, hospital record, clinic record, dialysis record, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed resident and staff interactions during the onsite visit.

The resident resided in an assisted living facility. The resident's diagnoses included diabetes, hyperglycemia (high blood sugar), chronic kidney disease, and end stage renal disease. The resident's service plan included daily safety checks and blood sugar checks four times daily. The resident's assessment indicated the resident was independent with his activities of daily living (ADL's) and able to self-administer insulin. The resident was alert and oriented and able to make his needs known. The resident walked independently and occasionally used a walker and cane.

The resident's progress note indicated on the 12th day of a month, at 12:15 p.m., a facility nurse called the dialysis clinic to check and see if the resident went to his dialysis appointments. The clinic indicated the resident missed his scheduled dialysis treatment on the 10th, his rescheduled treatment on the 11th, and regularly scheduled appointment on the 12th of the same month.

Another progress note documented two hours later indicated the resident showed signs of uremic toxicity. The resident's vital signs were obtained. A facility nurse noted the resident's dialysis tubing was completely exposed with redness and secretions coming out of the tubing. The resident was transported to the hospital.

The resident's hospital record indicated the resident had "no clue" why he missed his dialysis appointments. Facility staff called emergency medical services (EMS) after observing the resident appeared confused. The resident spent six days in the hospital where he received dialysis treatments. The resident returned to his baseline status and was discharged to the facility.

When interviewed, a facility nurse stated he implemented interventions to assist the resident in going to his dialysis appointments stating the resident's dialysis used to start at 6:00 a.m. but after talking to the resident the nurse was able to switch the resident's dialysis start time to 12:30 p.m. The nurse stated the facility began scheduling the resident's transportation to and from the dialysis clinic. The nurse stated after the resident's hospitalization he added nursing to monitor and ensure the resident made it to dialysis appointment and help him with rescheduling his appointment if he missed his treatment.

When interviewed, the resident stated he was insulin dependent for years and self-injected his own insulin when his blood sugars were high. The resident stated he would tell staff when he decided he was not going to his dialysis. The resident stated he did not recall missing medications and meals for five days.

In conclusion, the Minnesota Department of Health determined neglect was not substantiated.

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 called 911 to transport the resident to the hospital.

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
	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 On April 25, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL201918661C/#HL201919482M. No correction orders are issued.	0 000		