Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL304459662M
Compliance #: HL304459001C

Date Concluded: July 17, 2025

Name, Address, and County of Licensee Investigated:
The Lodge on Summit Oaks (The Lodges Co.)
1412 Summit Oaks Drive
Burnsville, MN 55337
Dakota County

Facility Type: Assisted Living Facility (ALF)

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 provide monitoring and supervision according to the resident's plan of care. The resident was left outside in sub-zero temperatures for an undetermined amount of time and developed blisters on his left hand.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The resident was told not to go outside because of extremely cold temperatures but the resident ignored staff's advice and went outside on his own accord. Once staff realized the resident was not in the facility, they immediately looked outside and saw the resident. The following day when the resident complained of pain and blisters on his hand the facility notified the resident's provider who sent orders for wound care.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's legal guardian. The investigation included review of the resident record, in-house provider records, images of the

resident's hand, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed interactions and cares between facility staff and residents during the onsite investigation.

The resident resided on the main level of a two-level assisted living facility. The resident's diagnoses included chronic obstructive pulmonary disease (COPD-a lung disease that makes it hard to breathe), acute respiratory failure with hypoxia (deficient blood oxygen to organs/tissues in the body), and muscle weakness. The resident's care plan included assistance with propelling his wheelchair on uneven surfaces and long distances. The resident was unable to walk and used a manual wheelchair for mobility and required staff assistance with transfers using a mechanical life (EZ stand). The resident's assessment indicated he was alert and oriented to person, place, and time, with an intact memory.

The resident's progress note indicated one winter day the resident sustained several large blisters on his left hand. The resident told staff the blisters were from wheeling himself down the driveway and trying to wheel himself up the driveway. Staff indicated they were unaware the resident was outside in the lower level until they performed a safety check and realized the resident was not in his room. The resident was reminded to always ask for help when wheeling himself up and down the driveway.

The resident's provider communication from a licensed staff member to the provider indicated the resident was unable to wheel up the driveway due to the steep hill and snow. The licensed staff person indicated the resident's blisters were likely a combination of friction burn and from the resident's hands being on the cold metal of his wheels.

The next day a provider communication to the licensed staff member, requested staff encourage the resident to avoid using his blistered hand to self-propel his wheelchair. The resident's hand was wrapped in gauze to reduce the resident's discomfort.

The resident's record indicated the resident's blisters healed several days later and wheelchair gloves were ordered for the resident.

When interviewed, an unlicensed personnel stated the resident was advised not to go outside because of the cold temperatures and avoid wheeling the resident's wheelchair to the lower level of driveway. The unlicensed personnel stated while they were in the kitchen preparing dinner the resident snuck outside of the facility and went down the hill to get a cigarette from another resident. The unlicensed personnel stated they were unaware the resident left the facility until they noticed he was not in the facility. The unlicensed personnel stated the resident did not mention the blisters or pain in his left hand until the following day.

When interviewed, leadership stated after the incident the facility looked at different interventions, such as making sure the resident wore hat and gloves before going outside and redirecting the resident when he was inside.

When interviewed, the resident's legal guardian stated the resident needed a lot of attention and was quick in propelling his wheelchair. The resident's legal guardian stated she received a call from the resident the day after the incident stating his hands hurt because he had frostbite from being outside. The legal guardian stated she reminded the resident that he should stay inside but stated the resident would still go and do what he wanted to do.

When interviewed, the resident stated, "I was frostbitten." The resident stated he went down the hill and then could not get back up stating he felt like he was going to fall back.

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: Not Applicable.

Action taken by facility:
The facility coordinated care with the resident's provider. In addition, the facility sent the resident to the emergency department to assess his blisters.

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
	30445	A. BUILDING: _____ B. WING _____	C 06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LODGE ON SUMMIT OAKS	1412 SUMMIT OAKS DRIVE 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 June 26, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL304459001C/#HL304459662M. No correction orders are issued.	0 000	Assisted Living Provider 144G. 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.	