Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL293627702M
Compliance #: HL293627763C

Date Concluded: April 1, 2026

Name, Address, and County of Licensee Investigated:
Arbors at Ridges Assisted Living
13897 Community Drive
Burnsville, MN 55337
Dakota County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Erin Johnson-Crosby, 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 facility staff transferred the resident using a mechanical standing lift, and the resident sustained multiple fractures.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. During a transfer with a mechanical lift the resident began screaming in pain. The resident was hospitalized with multiple fractures and died 12 days later. Furthermore, the facility failed to complete a thorough investigation to determine the root cause of the incident and did not implement interventions to prevent re-occurrence.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident record, death record, hospital records, facility internal investigation, facility incident reports, personnel

files, staff schedules, and related facility policy and procedures. During the onsite visit the investigator observed facility staff transfer residents with a mechanical standing lift.

The resident resided in an assisted living facility with diagnoses including dementia, heart failure, and osteoporosis. The resident's service plan included one staff assistance with a mechanical standing lift for transfers and toileting. The resident's assessment indicated the resident required an assist of one with a standing lift. The resident was weak, had low endurance, and decreased strength. The resident was oriented to person, place and situation but forgetful. The resident's record indicated that the resident denied pain and did not have a history of falls.

Facility documents indicated unlicensed personnel transferred the resident with a mechanical standing lift out of the bathroom into the hallway between the bathroom and bedroom. When the unlicensed personnel pushed the lift over the threshold into the hallway the resident began screaming in pain. While the resident was screaming in pain both legs turned in the same direction and appeared to give out. The resident was transferred to bed, and the unlicensed personnel called the nurse. The nurse observed the right knee appeared to be dislocated. The nurse contacted the family and emergency medical services (EMS). The report indicated the resident was in the mechanical standing lift when the incident occurred and it was unknown how the injury took place. Maintenance staff checked the mechanical standing lift after the incident and was functioning properly. The documentation did not include what specific standing lift was used during the transfer.

The resident's hospital record indicated the resident was brought in with knee pain after using a mechanical standing lift and noted the right knee may have gotten caught. The resident's family reported no previous chronic fractures. The residents' bilateral knees were swollen, with a left knee laceration. X-rays obtained indicated bilateral femur (leg) fractures, right humerus (arm) fracture and a sternal (chest) fracture. As the result of the fractures the resident was treated for hemorrhagic shock and severe anemia due to bleeding at various fracture sites. The record indicated there was a presumed fall with multiple fractures. The resident was not a surgical candidate and would utilize pain medication and immobilizers for pain management. The record indicated the information provided by the facility was inconsistent with the injuries and may have suffered some sort of fall or had multiple injuries over a short period of time. The resident spent six days in the hospital and returned to the facility with hospice services.

Twelve days after the incident the resident died. The resident's death record indicated the cause of death was related to an injury or trauma and the cause of death included complications of bilateral femur fractures, right humerus fracture, and a transfer device mishap.

The investigator received an email from hospital staff that indicated the registered nurse and the doctor were concerned that the facility description of the incident were inconsistent to the resident's multiple fracture. The hospital staff also noted that a sternal fracture would be sustained through direct pressure to the chest.

During an interview, the unlicensed personnel stated the resident was difficult to transfer with the mechanical standing lift because the resident could not bear weight and would dangle in the lift. Prior to the incident the unlicensed personnel attempted to get another staff member to assist with the transfer, but no one was available. The unlicensed personnel stated she had to use force while pushing the mechanical standing lift from the bathroom into the hallway, over the transition strip. After going over the transition strip the resident's legs appeared to turn to one side and the resident began screaming. The unlicensed personnel assisted the resident to bed and noticed the resident's knee looked abnormal, so she called the nurse. The unlicensed personnel thought the standing lift used for the transfer was not operating properly prior to the incident. Management was aware the resident was difficult to transfer with one staff and were also aware the standing lift did not function properly. During this transfer the leg strap was not used. After the incident staff must use the leg strap for all residents. The unlicensed personnel stated the resident did not fall out of the lift and did not know how the resident sustained so many fractures.

During an interview, the facility nurse stated she was summoned to the resident's room because the resident was in pain. When the nurse walked in the resident was in the standing lift and the unlicensed personnel attempted to sit the resident down in the wheelchair and the resident began to scream, so she told the unlicensed personnel to transfer the resident to bed. The unlicensed personnel and nurse assisted the resident into bed, and the nurse noticed the resident's left leg looked out of place. The resident kept pointing at her chest (sternal), but she did not see anything on the resident's chest. The only thing that appeared abnormal was the resident's leg. The nurse contacted emergency medical services, and the resident was transferred to the hospital.

During an interview, management nursing staff stated she did not complete an internal investigation to determine the root cause. Interventions were not implemented following the incident to prevent re-occurrence.

During an interview, the resident's family member stated the resident did not remember the incident and facility could not tell them how the resident sustained so many fractures. The doctor informed the family that the resident's injuries were not minor and were not consistent with the facility description of the incident. The resident was not a good surgical candidate and would possibly require two surgeries, with multiple surgeons working on the resident at the same time and the resident may not have survived the surgery. The resident received a lot of pain medications for the multiple fractures and passed away 12 days after the incident.

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: No, the resident was deceased
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
The facility reported it and sent to the hospital.

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
	29362	A. BUILDING: _____ B. WING _____	C 01/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBORS AT RIDGES ASSISTED LIVI	13897 COMMUNITY 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 ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are 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: #HL293627763C/#HL293627702M On January 28, 2026, 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 61 residents receiving services under the provider's Assisted Living license. The following correction orders are issued for #HL293627763C/#HL293627702M tag identification 1420, 2310, 2360.	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.	
01420 SS=F	144G.62 Subd. 2 Delegation of assisted living services	01420		

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01420	Continued From page 1 (b) When the registered nurse or licensed health professional delegates tasks to unlicensed personnel, that person must ensure that prior to the delegation the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each resident and is able to demonstrate the ability to competently follow the procedures and perform the tasks. If the unlicensed personnel has not regularly performed the delegated assisted living task for a period of 24 consecutive months, the unlicensed personnel must demonstrate competency in the task to the registered nurse or appropriate licensed health professional. The registered nurse or licensed health professional must document instructions for the delegated tasks in the resident's record. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure unlicensed personnel (ULP)-H, ULP-I, ULP-J, ULP-K, and ULP-L) completed all training and competency evaluations prior to providing delegated nursing tasks to three of three residents (R2,R3, R4) utilizing a mechanical standing lift. 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On January 28, 2026, at 11:02 a.m., unlicensed personnel (ULP)-H and ULP-I transferred R2 with	01420	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	

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01420	Continued From page 2 a WeStand mechanical standing lift. ULP-H stated this lift was new. ULP-H and ULP-I put the belt around R2 but did not tighten the belt. As R2 was lifted with the mechanical stand ULP-H or ULP-I did not tighten the belt when standing up. ULP-H and ULP-I stated the belt should have initially been tightened and then re-tightened while R2 stood up. On January 28, 2026, at 11:15 a.m., ULP-J and ULP-K transferred R3 using an EZ WAY mechanical standing lift. ULP-J put the belt around R3 and did not initially tighten the belt. While R3 was lifted with the mechanical stand ULP-J nor ULP-K tightened the belt and was very loose. ULP-J stated she did not tighten the belt before or during the transfer but they were supposed to so the residents would be more stable during the transfer. On January 28, 2026, at 11:30 a.m., ULP-L transferred R4 with the NORA Alu mechanical standing lift. ULP-L put the belt around R4 but did not tighten the belt. ULP-L lifted R4 up but did not tighten the belt. ULP-L stated she should have tightened the belt but R4 would complain if the belt was tightened too much. On January 28, 2026, at 1:20 p.m., registered nurse (RN)-C stated staff should tighten the belt but stated did not know if the staff needed to tighten while the resident stood up with the lift. RN-C stated staff should follow manufacturers' guidelines while using standing lifts. On January 28, 2026, at 1:45 p.m., RN-M stated the standing lift belt should be tightened when it is put on and while the residents are standing up. Lifts should be used per manufacturers' guidelines. The company would have to look at	01420	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.	

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01420	Continued From page 3 their competencies and policies to ensure staff were trained on each type of mechanical stand. On January 28, 2026, at 15:30 p.m., RN-C stated a resident service coordinator (RSC) was not a licensed staff but was assisting with competencies. The RSC started in September 2025, so the facility was trying to get caught up on competencies. RN-C stated ULP-H, ULP-I, ULP-J, ULP-K, and ULP-L provided direct care to the residents including mechanical standing lift transfers. The investigator requested the competencies for the ULP's. RN-C stated the competencies were not in the employee files but did not mean it had not been completed. WeStand manufacturers guidelines dated December 2021, indicated the inner safety belt should be fastened snuggly. EZ Way, Inc. Quick Reference Guide dated November, 8, 2023, indicated the safety belt/harness should be the correct size. Ensure the safety strap is buckled and fastened securely around the person's torso and arms outside the harness. While raising to a standing position, tighten the safety strap around the torso while they are raised. Nora manufacturer's guidelines dated August, 2019, indicated the sling/belt should be fasted to the belly part. Ensure the correct sling size and is adjusted to the resident and ensure the resident's arms were located outside the sling. The licensee's undated On Site Skills Assessment Demonstration/Competency Orientation Checklist- Lifts- Easy Stand and Universal indicated all resident assistants would be trained on the appropriate use of the	01420		

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01420	Continued From page 4 equipment and demonstrate competencies at least annually. Adjust the tightly of the sling/belt by buckling the belt and adjusting it until it is snug but comfortable. The licensee's Standing Lift Assist policy dated, September 2021, indicated the nurse would assess each resident to determine the resident's need for transfer assistance with a standing lift. All resident assistant staff will be trained on the appropriate use of the equipment and will demonstrated competencies at least annually. Attach the appropriate sling/belt so the label faces outside away from the resident. Adjust the tightness of the sling by buckling the belt and adjusting it until it is snug but comfortable. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01420		
02310 SS=J	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 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 ensure one of one resident (R1) received necessary care and services, during a transfer with a mechanical sit to stand lift, R1 was hospitalized with bilateral distal femur fractures (break in the lower part of the thigh bone, just	02310		

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02310	Continued From page 5 above the knee), right humerus fracture (break in the upper part of the humerus bone located near the shoulder) and sternal fracture (break in the breastbone, located in the center of the chest). R1 passed away 12 days after the incident. Furthermore, the facility failed to conduct a thorough investigation and implement systemic changes to attempt to prevent recurrence. This practice resulted in a level four violation (a violation that harmed a resident's health or safety, not including serious injury or death, or a violation that was likely to lead to serious injury 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). Findings include: R1's face sheet indicated R1 was admitted to the licensee on August 30, 2023. Diagnoses included dementia, congestive heart failure, and osteoporosis. R1's service plan effective November 6, 2025, indicated R1 required transfer assistance with one staff with a sit to stand lift. The plan also indicated R1 required physical assistance with toileting every three hours and required assistance from staff to transfer. R1 quarterly assessment dated September 18, 2025, indicated that R1 required assistance of one and a sit to stand lift for transfers, including toileting. R1 had weakness, difficulty weight bearing, low endurance and decreased strength. R1 was orientated to person, place and situation but was forgetful. R1 denied pain. The assessment indicated R1 did not have a history of falls.	02310		

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02310	Continued From page 6 R1's incident report dated November 7, 2025, at 6:00 p.m., indicated R1 was in bed when the nurse arrived. Unlicensed personnel (ULP)-A reported while transferring R1 off the toilet using the standing lift there was a transition strip between the bathroom and hallway. The ULP had to force the lift off the transition strip and R1 began screaming in pain. When R1 yelled both legs turned in the same direction, like R1's legs gave out. ULP-A placed R1 in the wheelchair and attempted to contact another staff for assistance but could not get assistance so ULP-A transferred R1 to bed. R1 moaned a few times but did not scream. R1 reported decreasing pain as the time passed. ULP-A contacted the nurse. The nurse indicated the right knee appeared to be dislocated. The nurse called the family and emergency medical services (EMS). The report indicated R1 was in the standing lift when the event happened, and it was unknown how the injuries took place. Maintenance checked the standing lift after the incident and the equipment was functioning properly. The report also indicated physical therapy (PT) had evaluated R1 one year ago and recommended R1 use a full body mechanical lift. R1's medical record did not include PT recommendations or R1's refusal of the mechanical full body lift. R1's medical record did not include a risk versus benefit regarding refusals of a full body mechanical lift. R1's PT notes were requested but not provided. R1's hospital records dated November 7, 2025, through November 13, 2025, indicated R1 was brought in with knee pain after being lifted in a mechanical stand and the right knee may have gotten caught. R1's family reported R1 did not	02310		

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02310	Continued From page 7 have known chronic fractures. R1's bilateral knees were swollen on exam with a left knee laceration. X-rays revealed bilateral femur fractures, right arm humerus fracture, with a large bruise and fracture to the body of the sternum. In addition to the fractures R1 was treated for hemorrhagic shock requiring norepinephrine (used to maintain tissue perfusion and prevent organ failure) and received 3 units of blood. R1 had severe anemia resulting in shock due to apparent blood loss presumed to be due to bleeding into the various fracture sites. . R1 was not a surgical candidate and would wear splints/immobilizer and pain medication for comfort. The hospital records indicated there were multiple fractures involving the arm, bilateral knees and the sternum seemed inconsistent with the limited information provided by the facility. There were concerned R1 had suffered some sort of fall or may have had multiple injuries over a short period of time. R1's progress notes dated November 13, 2025, indicated R1 had osteoporosis and had a fracture during a transfer. The resident was in a lot of pain during the transfer from the stretcher to the bed. R1 had bilateral leg braces on bilateral legs, and sling for right arm. R1 was non-weight bearing on the right upper extremity and bilateral lower extremity. The facility internal investigation dated November 14, 2025, indicated R1 was in sit to stand lift in the bathroom and ULP-A moved R1 out of the where the wheelchair was located. The standing lift was pushed over the bump/threshold and R1 yelled like she was hurt. ULP-A stated both legs turned in one direction like they gave out. The standing lift was inspected for functionality after the incident, and no deficiencies were found. The	02310		

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02310	Continued From page 8 section titled, corrections to prevent re-occurrence was blank. The internal investigation did not include the type of sit to stand lift that was used during the incident. R1's death record dated November 19, 2025, indicated R1's death was related to an injury or trauma with the cause of death listed as complications of bilateral femur fractures and right humerus fracture, and a transfer device mishap. On February 19, 2026, at 12:30 p.m., ULP-A stated she assisted R1 to the toilet using the sit to stand lift. Prior to getting R1 off the toilet ULP-A requested assistance from another staff because R1 was difficult to transfer, however, the co-worker was busy, so ULP-A continued the transfer herself. ULP-A pushed the sit to stand lift from the bathroom with linoleum flooring into the hallway with carpeting. ULP-A had to use force to push the lift over the transition strip. While going over the transition strip R1 screamed loudly and both legs appeared to turn towards one direction like they gave out, but after a few minutes R1 stopped screaming. R1 was in bed and noticed R1's knee looked "weird," so ULP-A called the nurse. R1 could not bear weight or stand up so R1 was difficult to transfer with the sit to stand lift with one person. ULP-A reported to management that R1 should have been a full body lift. ULP-A stated R1 did not fall or slide out of the sit to stand lift and did not know how the fractures occurred. Prior to this incident ULP-A notified management that the lift had not been functioning properly. ULP-A stated the leg strap were not used for R1's transfer. ULP-A stated no residents in the facility used the leg straps. Following the investigators' onsite visit management instructed to start utilizing the leg strap for all residents.	02310		

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(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
02310	Continued From page 9 On February 24, 2026, at 11:30 a.m., licensed practical nurse (LPN)-E stated she was called by ULP-A after R1 was transferred with a standing lift and screamed out in pain. LPN-E walked in while ULP-A was attempting to sit R1 in the wheelchair, but R1 began screaming in pain again so LPN-E instructed ULP-A to transfer R1 to bed. LPN-E stated after assisting R1 to bed she noticed R1's leg looked abnormal and appeared dislocated. R1 kept pointing at her chest (sternum) but nothing was observed on R1's chest. LPN-E called EMS, and R1 was transported to the hospital. LPN-E did not know how R1 sustained multiple fractures. On February 24, 2026, at 9:30 a.m., the registered nurse (RN)-C stated the evening of the incident she received a call from LPN-E that something had happened during a transfer with the mechanical standing lift and thought R1's knee was dislocated. LPN-E contacted EMS. RN-C stated she had not completed an internal investigation before and verified the investigation lacked information to determine a root cause and interventions to prevent reoccurrence. RN-C stated staff did not report R1 was difficult to transfer. RN-C did not know why R1 was assisted with one staff and the standing lift if PT had recommended the full body lift. RN-C also stated that staff did not have to use the leg strap on the mechanical standing lifts and did not know if the leg strap was used during R1's transfer. RN-C did not know how R1 sustained multiple fractures. After the investigator's onsite visit the facility started to train on each type of mechanical lift per manufacturers guidelines and the facility policies were being updated to reflect those changes. The facility also began reassessing resident's using mechanical lifts to ensure the lifts were	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29362	A. BUILDING: _____ B. WING _____	C 01/28/2026

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02310	Continued From page 10 appropriate for the residents. On February 19, 2026, at 3:00 p.m., the family member (FM)-B stated it was not clear what happened or how R1 sustained so many fractures. FM-B stated he thought someone should have stepped forward and told them what really happened. The doctor informed the family R1's injuries were not minor and were not consistent with what the facility had reported. FM-B stated R1 could not remember what happened. FM-B stated R1 did have a fracture from a fall a few years ago but no recent fractures. An email dated March 2, 2026, sent by nurse (RN)-G indicated hospital staff were concerned about the details described by the facility were not consistent with the resident's injuries of bilateral femur fractures, right humerus fracture and a sternal fracture. Per the doctor and RN-G's nursing knowledge a sternal fracture would sustained through a direct pressure to the chest. With all the injuries the resident was not a candidate for surgery and was placed on comfort care/hospice cares for end of life. WeStand standing lift manufacturers' guidelines dated December 2021, indicated staff should snuggly fasten the knee strap behind the patient's knees. EZ Way manufacturers' guidelines dated November 8, 2023, indicated if a caregiver deemed it necessary to keep a patients shin or feet on the foot plate, secure the shin strap around the patient's legs. Nora Alu standing lift manufacturers' guidelines dated August 2019, indicated when lifting a	02310		

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02310	Continued From page 11 patient, the leg safety belts must be closed. The licensee's Vulnerable Adult reporting and Investigation policy dated December 2, 2020, indicated occurrences of suspected abuse, neglect or financial exploitation will be investigated by the director of health services (DHS) in coordination with the executive director (ED). The DHS will coordinate with the ED regarding the investigation of any incident and implementation of any necessary steps to reduce the risk of other similar incidents. The licensee's Standing Lift Assist policy dated September 1, 2021, indicated the nurse will assess each resident to determine the resident's need for transfer assistance with a stand assist lift. The service plan will reflect the use of the equipment in providing services for the resident. All ULP's will be trained on the appropriate use of the equipment and will demonstrate competencies annually. The policy indicated the shin strap should be secured around the resident's legs if applicable. The policy also indicated care and maintenance should be done routinely per a preventative maintenance program. No additional information was provided. 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.	02360		

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02360	Continued From page 12 This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident 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	Refer to the maltreatment report sent separately. No plan of correction is required for this tag.	