Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H55137362M
Compliance #: H55135170C

Date Concluded: February 9, 2026

Name, Address, and County of Licensee Investigated:
Lake Ridge Care Center of Buffalo
310 Lake Boulevard South
Buffalo, MN 55313
Wright County

Facility Type: Nursing Home

Evaluator's Name: Kris Detsch, RN
Special Investigator

Finding: Inconclusive

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):
AP #1, who was a nurse, and AP #2, who was a nursing assistant, neglected the resident when they failed to transfer the resident correctly using a Hoyer (mechanical lift). As a result, the resident slid out of the Hoyer lift and fell onto her back and shoulders.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive for AP #1. It could not be determined when and who placed the incorrect sling size in the resident's room. The resident's care plan required a size medium sling and multiple staff, including AP #1, used the large sling that was in her room. AP #1 hooked up the resident to the Hoyer lift and possibly in error connected the sling loops to the Hoyer four-point hooks by double looping. At some point during the transfer one of the loops from the sling detached form the Hoyer resulting in the resident sliding out of the sling onto the floor. The resident sustained a left rib fracture but did not require further treatment for this injury. The facility provided proper training to staff and were unaware staff were following an erroneous order by continuing to use the wrong sling

size. After the fall, the facility immediately inspected the equipment and provided re-education to the staff. This was an isolated incident.

The Minnesota Department of Health determined neglect was not substantiated for AP #2. AP #2 arrived to be the second person transfer assist after AP #1 had the sling placed under the resident ready to be hooked up to the Hoyer lift. Because the sling size was located inside of the sling, AP #2 would not have been able to confirm if the correct sling size was used.

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

The resident resided in a skilled nursing facility. The resident's diagnoses included multiple sclerosis (disease effecting the central nervous system resulting in mobility limitations). The resident also had other mobility limitations from a past stroke (brain bleed). The resident's care plan indicated she required a Hoyer lift and two staff members to transfer her because she could not stand or walk. The care plan indicated she was alert and orientated.

The resident's care plan indicated she was assessed and required a medium sling size. The resident's weight indicated she would have been significantly under the minimum weight requirement for a large sling size.

A facility incident report indicated the resident fell from the Hoyer lift and hit her left shoulder during the transfer from her bed into her wheelchair. The report indicated AP #1 and AP #2 performed the transfer. The report indicated the resident required a medium size sling, but staff used a large size sling. The report indicated the sling loosened from the hook (connected to the Hoyer), and the resident fell back and hit her left shoulder on the lower part of the Hoyer. The report indicated the resident had pain in the left side of her body including her shoulder, back, arm, and rib area. The report indicated staff informed her physician and obtained imaging (X-ray) of her shoulder and ribs. Initial X-ray results indicated the resident had a fracture of her upper left rib. The report indicated the facility re-trained their staff immediately on the use of mechanical lifts.

Two days after the incident, a nurse practitioner (NP) assessed the resident at the facility. NP records indicated the resident had a left rib fracture from the fall. The records indicated she was "doing well," but had left rib pain when she moved around. The records indicated the resident's health declined prior to this incident and she required hospice care. The records indicated hospice care was to start the same day.

During an interview, a manager said staff members called him and informed him of the incident. The manager said AP #1 and AP #2 were the two staff who used the Hoyer at this time. The manger said the facility leadership inspected all Hoyer machines and their slings, including the

equipment used in this event. The manager said the items were intact, and functioning properly. The manager said according to the facility's mechanical lift policy, staff were to perform a procedure called "Pause for the Cause." This was an additional safety measure staff were to use after they connected the sling to the Hoyer. Staff were to lift the resident up from the bed then "pause" (stop the transfer) and observe all the connecting points to ensure the sling connected to the Hoyer properly before they moved the resident away from the bed. The manager said AP #1 and AP #2 failed to complete this task. The manager said the facility immediately assessed all the equipment and re-trained their staff. The manager said they contacted the company who made the Hoyer, and they sent a representative to the facility to provide mandatory training to all staff. The manager said the facility's physician told them there was no fracture, however, second images indicated the resident had a fracture of her rib. The manger said the facility completed a formal investigation of the incident.

During an interview, AP #1 said the Hoyer sling was in the resident's room, so she placed the sling under the resident, then called for another staff member to help her transfer the resident out of her bed into the wheelchair. AP #1 said AP #2 responded and brought the Hoyer with her. AP #1 said they both hooked the sling to the Hoyer and proceeded with the transfer. The Hoyer lifted the resident up from her bed, then they moved her away from the bed to position her into her chair. During this process, one loop of the leg strap disconnected from the Hoyer and the resident fell to the floor. AP #1 said the Hoyer sling contained three loops at each point of the sling (four straps total need to connect to the Hoyer). The loops were of differing lengths which allowed for various positioning once connected to the Hoyer. AP #1 said when the representative from the Hoyer lift company provided re-education, she told them they should only connect one loop to each hook during a transfer. They were not to "double loop" (connect two loops) to a hook (this could interfere and cause loops to disconnect). AP #1 said she was unsure if she double looped at the time of the transfer. AP #1 said there were no malfunctions of the equipment. AP #1 said "pause for the cause" was not in place at the time of the incident.

During an interview, AP #2 said when she arrived in the room, AP #1 had already placed the sling under the resident. She helped AP #1 connect the loops to the Hoyer. AP # 2 said she connected the upper loops; AP #1 connected the lower loops. AP #2 said nothing seemed unusual with the connections. AP #2 said she did not see the loop disconnect. AP #2 said when the Hoyer lifted the resident from her bed, nothing seemed unusual, and the Hoyer did not "rock" or move. AP #2 said as she moved the Hoyer out from the resident's bed, AP #1 positioned the wheelchair, when the incident occurred. AP #2 said after the nurses assessed the resident; they obtained different equipment and lifted the resident into her chair. AP #2 said she did not check the sling size because AP #1 already placed the sling under the resident before she arrived. AP #2 said the facility re-trained the staff and told them not to double-loop the hooks. AP #2 said she checked the loops she connected to the Hoyer, but not the ones AP #1 connected. AP #2 said Hoyer slings remain in the resident's room, but whoever gives the resident a shower, obtains a new sling because the current sling gets wet from the shower. AP #2 said the resident had a shower the night prior.

The facility's internal investigation indicated when interviewed, the resident said she felt safe with AP #1 and AP #2, and she did not feel they operated the Hoyer carelessly.

In conclusion, the Minnesota Department of Health determined neglect was inconclusive for AP #1.

In conclusion, the Minnesota Department of Health determined neglect was not substantiated for AP #2

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or did not occur.

"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: No. Deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes. AP #1 and AP #2.

Action taken by facility:
The facility immediately inspected all equipment, and provided re-education to staff members. They facility informed the resident's provider who ordered an X-ray.

Action taken by the Minnesota Department of Health:
MDH previously investigated the issue during a complaint survey under federal regulations, and substantiated facility 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.

You may also call 651-201-4200 to receive a copy via mail or email.

The purpose of this investigation was to determine any individual responsibility for alleged maltreatment under Minn. Stat. 626.557, the Maltreatment of Vulnerable Adults Act.

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 CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **01/21/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE RIDGE CARE CENTER OF BUFFALO, INC.	**310 LAKE BOULEVARD , BUFFALO, Minnesota, 55313**

(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) COMPLETION DATE
20000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: The Minnesota Department of Health investigated an allegation of maltreatment, complaint #H55137362M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. No correction orders are issued. The facility is enrolled in the electronic Plan of Correction (ePoC) and therefore a signature is not	20000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **01/21/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE RIDGE CARE CENTER OF BUFFALO, INC.	**310 LAKE BOULEVARD , BUFFALO, Minnesota, 55313**

(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) COMPLETION DATE
20000	Continued from page 1 required at the bottom of the first page of the State form. Although no plan of correction is required, it is required that you acknowledge receipt of the electronic documents.	20000		