

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL304743802M
Compliance #: HL304747348C

Date Concluded: August 25, 2025

Name, Address, and County of Licensee

Investigated:

Deephaven Woods Senior Living
18025 Minnetonka Boulevard
Deephaven, MN 55391
Hennepin County

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

Evaluator's Name: Willette Shafer, 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 alleged perpetrator (AP) neglected the resident during a transfer when the AP lowered the resident to the floor and the resident fractured her back.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined neglect was not substantiated. It was unforeseen the resident would become unsteady during a standing lift transfer and the AP lowered her to the floor for safety. Although a fracture was diagnosed a few days after the incident, the resident complained of back pain the day before the incident occurred. The x-ray confirmed cracks in several vertebrae and was possibly age related. The resident recovered from her injury and returned to her baseline health condition.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted a family member. The investigation included review of the resident's record, hospital records, facility internal

investigation, facility incident report, personnel files, staff schedules, related facility policy and procedures. Also, the investigator toured the facility and observed staff assisting residents with mechanical transfers.

The resident resided in an assisted living facility. The resident's diagnoses included osteoporosis, spondylosis of lumbar area (weakened bones in spine/ vertebrae), and weakness in both lower extremities. Spondylosis is breakdown of the vertebrae and causes the bones to become more brittle and prone to fractures, particularly stress fractures (cracks and breaks caused by stress and strain). The resident's service plan included assist of one staff with dressing, grooming, and transferred with a standing lift and physical assist with staff at times.

The resident's progress notes indicated the resident had chronic back pain that became worse a week before the incident. The resident used ice packs and personal supply of over-the-counter medication to manage her pain. The nurse recommended the resident go to the hospital if the pain was unmanageable. The progress notes about the incident indicated the resident and AP reported the resident was lowered to the floor. The AP reported the resident was leaning too far forward during transfer to safely continue transfer. The resident denied any increased back pain after the incident. The primary care provider assessed the resident the day after the incident for routine visit. The provider ordered therapy and nonpharmacological interventions to manage pain.

The internal investigation indicated the resident complained of pain several days before she was sent to the hospital. The resident said her back hurt because she sat in her chair too long the day before the pain began. The resident was wheelchair bound with "severe kyphosis." Her primary care provider was notified, and she was treated with over-the-counter pain medication and ice. The resident's care plan was followed.

The resident's hospital record indicated the resident's vertebral fracture may have been a pathological fracture (due to underlying disease). The resident's computerized tomography (CT) results indicated significant loss of bone mineral density, making bones weak and susceptible to fractures. The CT also indicated multiple subacute compression fractures (old fractures that have not healed completely).

During an interview, the AP said he transferred the resident with the standing lift as per her care plan. During the transfer the resident complained of pain, and she was leaning to one side more than usual. He felt it was unsafe continue with the transfer, so he got behind the resident and lowered her to the floor with the standing lift. He said she never fell and never complained of pain while sitting on the floor. The AP called another unlicensed personnel (ULP) for assistance to help the resident off the floor. The AP and ULP assisted the resident off the floor with a gait belt and one on each side lifting her into her chair. He said the resident requested staff lift her that way because she did not want to use a lift. Once the resident was back in her chair, she reported she felt better. He said he used the standing lift to transfer her back into bed

at night and she never complained of pain during that transfer. He reported the incident and the resident's pain to the nurse.

During an interview, ULP indicated the AP called him to assist with the resident. When he arrived at the resident's room she was sitting on her apartment floor. The AP said he lowered her to the floor because she was weak and unable to transfer. The resident denied she fell. The ULP and AP physically assisted the resident back to her chair with a gait belt. He said the resident never complained of any injuries when they assisted her back to her chair.

During an interview, the nurse said the resident complained of pain a day or two before the incident. During the incident, the AP lowered the resident to the floor mid transfer due to the resident's positioning. The resident was leaning too far over and it was unsafe to continue with the standing lift transfer. The resident also reported the AP lowered her to the floor. The AP and ULP assisted the resident back into her chair. The resident continued to complain of pain and the provider assessed her. The resident declined to go to the hospital. The facility used pain medication and ice to alleviate discomfort. A couple days later the resident complained of abdominal discomfort along with back pain and the resident's family took her to the hospital. The resident was diagnosed with a fracture in her spine, completed rehabilitation and transitional care unit, and has returned to the facility at a similar level of independence as before.

During an interview, the family member said the x-ray completed at the hospital showed several cracked vertebrae. The hospital reported this was common for someone of the resident's age. She said the resident had a good memory and would have reported a fall, injury, or abuse. The family member had no concerns with the facility and said the resident received good care.

During an interview the resident said she loved living at the facility. She was unable to recall a specific event when she injured her back but said she never fell. She denied any abuse from staff and said they treated her "like a mother."

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: Yes.

Action taken by facility:

The facility alerted the provider of the resident's increase pain. The primary care provider assessed the resident and ordered interventions for pain management. The facility conducted an internal investigation and sent the resident to the hospital when pain worsened.

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30474	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/24/2025
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NAME OF PROVIDER OR SUPPLIER DEEPHAVEN WOODS SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 18025 MINNETONKA BOULEVARD DEEPHAVEN, MN 55391
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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
0 000	<p>Initial Comments</p> <p>On July 24, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL304747348C/#HL304743802M. No correction orders are issued.</p>	0 000		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____