Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL337271640M
Compliance #: HL337276346C

Date Concluded: July 6, 2026

Name, Address, and County of Licensee Investigated:
Scandi Haven of Cura
1710 McKinney Ave.
Benson, MN 56215
Swift County

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

Evaluator's Name:
Jana Wegener, 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 resident was neglected when the facility failed to ensure safety with falls prevention then failed to assess the resident for injuries after a fall occurred. The resident sustained serious injuries and was admitted to hospice then died.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The resident walked independently prior to the fall occurring and the care plan was followed at the time of the incident. The resident was diagnosed with COVID-19 one week prior to the fall causing a decline including decreased intake, weakness, and increased pain requiring the use of a wheelchair. When the unwitnessed fall occurred, the resident was assessed for injuries by nursing with none noted. The resident was admitted to hospice related to Alzheimer's disease. The resident's record of death indicated the resident died of natural causes related to Alzheimer's dementia.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family member. The investigation included review of the resident record(s), outside medical records, hospice documentation, facility incident reports, staff schedules, death record, grievances, and related facility policy and procedures. Also, the investigator observed residents and staff in the secure memory care unit.

A concern arose when it was reported the facility failed to ensure the resident's safety to help prevent falls then failed to assess the resident for injuries after a fall occurred. The concern indicated the resident had sustained serious injuries including a suspected hip fracture, with severe bruising and pain, then was admitted to hospice for end-of-life care and died.

The resident resided in an assisted living facility secure memory care unit with diagnoses including Alzheimer's disease, dementia with other behavioral disturbance, sacroiliitis (painful inflammation of one or both sacroiliac joints), spondylosis (age related wear and tear affecting the spinal disks, joints, and bones of the spine) lumbar region, history of wedge compression fracture (a spinal injury where the front of a vertebrae collapses but the back remains intact) of first and second lumbar vertebra, and osteoarthritis. The resident's assessment and plan of care prior to the fall incident indicated the resident required assistance with dressing and had routine safety checks daily. The assessment and plan of care indicated the resident's gait and balance were normal and she required no assistance with ambulation. The resident record indicated the resident had no falls since admission prior to the fall incident.

About two months after the resident was admitted to the facility a progress note indicated the resident was diagnosed with COVID-19.

Four days after the resident's COVID diagnosis, a facility communication to the resident's provider indicated the resident was experiencing nausea and vomiting and was prescribed Zofran. The resident record indicated that the resident had decreased intake, weakness, and was provided additional assistance including toileting assistance, transfer assistance, and had been using a wheelchair for mobility prior to the fall incident occurring.

Seven days after the resident's COVID diagnosis, a fall incident report indicated the resident had an unwitnessed fall out of her wheelchair. The report indicated the resident was observed sitting on the floor in front of her wheelchair which was being used due to her chronic lower back pain prior to the fall. The incident report indicated staff immediately notified the nurse. The report indicated the nurse assessed the resident for injuries including range of motion, with no injuries noted. The resident denied having any pain or hitting her head after the fall occurred. The resident was assisted back into her wheelchair without any issues. Later that day a progress note indicated the resident was repeatedly trying to stand up from her wheelchair.

Two days after the fall incident occurred a progress note indicated the resident was observed walking the hallways.

Five days after the fall incident occurred and 12 days after the resident was diagnosed with COVID-19 a facility faxed communication to the resident's provider indicated the resident had a significant decrease in overall wellbeing, was not conversing, with an increase in pain even with the use of as needed medications but was unable to state where her pain was. The communication indicated that the facility spoke with the resident's family who expressed wanting the resident to be comfortable and discussed Hospice for end-of-life care with the family in agreement. The fax indicated a referral for hospice was requested.

Later that same day a provider after visit summary (AVS) indicated the resident's family member brought the resident to be seen at urgent care for concerns of severe low back pain over the last 3 days. The AVS indicated the resident had a history of bad back pain. The AVS indicated the resident had limited right leg movement and right hip pain when assessed but failed to indicate the resident had a suspected hip fracture or other serious injuries related to the fall incident five days prior. The AVS indicated due to the resident's significant cognitive decline, increased confusion, and reduced verbal communication imaging and surgical interventions would not be recommended and the resident was referred to hospice for end-of-life care. As a result, no possible injuries were identified or ruled out.

The following day the resident's hospice admission documentation indicated the resident was admitted to hospice for end-of-life care related to Alzheimer's dementia.

The resident's record of death indicated the resident died of natural causes related to Alzheimer's Dementia four days after being admitted to hospice. The record of death failed to indicate the resident's death was related to an accident or injury related to the fall.

When interviewed several unlicensed staff indicated after the resident was diagnosed with COVID-19 she had increased weakness was more unsteady, had decreased intake, and moaned/whined more. Staff indicated during that time the resident was provided additional assistance with transfers/mobility, toileting, and eating/drinking. Staff indicated after the fall incident the resident transferred and moved her arms/legs normally.

When interviewed two nurses stated the resident was using her wheelchair at the time of the fall due to weakness from COVID-19 and chronic back pain. The nurses stated after the resident fell they assessed for injuries with normal range of motion and no signs of injury noted.

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: No, deceased
Family/Responsible Party interviewed: Yes, son. Daughter/POA did not respond to interview attempts.

Alleged Perpetrator interviewed: NA

Action taken by facility:
After the resident fell, staff notified nursing who assessed the resident for possible injuries with none noted. Although the facility did not inform the residents family member timely after the fall incident occurred and failed to notify the provider of the incident. A grievance form indicated that the facility re-educated all staff and updated their process to ensure the family and provider were notified of all incidents involving the residents in a timely manner.

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
	33727	A. BUILDING: _____ B. WING _____	C 05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCANDI HAVEN VILLAGE	1710 MCKINNEY AVENUE BENSON, MN 56215

(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 May 7, 2026, the Minnesota Department of Health initiated an investigation of complaint #HL337271640M/#HL337276346C. No correction orders are issued.	0 000		