

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL373021860M
Compliance #: HL373026884C

Date Concluded: April 8, 2026

Name, Address, and County of Licensee

Investigated:

Haven Homes Senior Living
4848 Gateway Boulevard
Maple Plain, MN 55359
Hennepin County

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

Evaluator's Name: Jennifer Segal RN, BSN
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 the resident when staff used a mechanical standing lift to transfer the resident. During the transfer, the staff member lowered the resident to the floor, and the resident sustained a femur fracture.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined neglect was not substantiated. The resident sustained a fracture, but there was insufficient evidence to attribute the injury to staff. The resident had osteoporosis, a history of fractures and x-ray indicated the femur fracture was pathological therefore it could not be determined when or how the fracture occurred.

The investigator conducted interviews with facility staff, including administrative, nursing, and unlicensed staff, as well as the outside hospice provider. The investigation included a review of the resident's facility and hospice records, the death certificate, internal investigation reports,

personnel and training records, and facility policies and procedures. The investigator also observed the unit and care provided, including mechanical lift transfers.

The resident resided in an assisted living memory care unit with diagnoses including dementia and osteoporosis. The residents' services included assistance with all activities of daily living including a mechanical standing lift. The resident's assessment indicated she was unable to communicate her needs, non ambulatory, had generalized pain and enrolled in hospice services for over one year.

A facility incident report indicated that during a routine mechanical stand transfer from the resident's chair to the hospital bed, the resident began to fall. The staff member lowered the resident to the floor and called for assistance. The resident did not report pain or display nonverbal signs of pain. Two staff members assisted the resident into bed and notified the facility nurse. The nurse assessed the resident and contacted hospice.

The resident record indicated a provider examined the resident, adjusted her medication, applied ice packs, and directed facility staff to keep the resident bedbound and non-weight-bearing until a mobile x-ray could be completed and further direction was provided by the provider.

The resident record indicated that the provider reviewed X-rays and examined the resident. Imaging showed a femur fracture and widespread reduced bone density consistent with a pathological fracture. The treatment plan included comfort measures, a leg immobilizer, bed rest, and no weight-bearing or range-of-motion movement of the affected leg.

During an interview, a staff member present on the day of the incident reported that they had used the mechanical lift successfully for the resident on many previous occasions and that the incident was unexpected. The staff member stated the lift operated correctly when they lowered the resident to the floor.

During interviews, several licensed and unlicensed staff members stated the mechanical lift functioned well for both the resident and staff. They reported no concerns or observed issues with the residents' safety or comfort during their use over several months.

During an interview, a manager stated there were no concerns about the staff member, who provided "excellent" care. Following the investigation, the facility coached the staff member to call a nurse before assisting a resident off the floor. The staff member also redemonstrated the correct use of all mechanical lifts used at the facility.

During an interview, the outside provider reported the resident's fracture was pathological and stated that when the fracture occurred was unknown. The provider reported visiting the resident at the facility multiple times over several months and stated that staff were consistently kind and competent and went "above and beyond expectations".

During an interview, the resident's family stated they visited frequently, that the resident had lived at the facility for years, and that they had no concerns, and that the staff took "wonderful" care of the resident.

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

Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:

After the facility completed an internal investigation, it provided a review of mechanical lift transfers and emergency procedures to all staff and updated a frequently used communication tool.

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: 37302	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/10/2026
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NAME OF PROVIDER OR SUPPLIER HAVEN HOMES ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 4848 GATEWAY BOULEVARD MAPLE PLAIN, MN 55359
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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 March 10, 2026 the Minnesota Department of Health initiated an investigation of complaint #HL373021860M/ #HL373026884C. No correction orders are issued.</p>	0 000		

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