Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H51646303M
Compliance #: H51643860C

Date Concluded: December 11, 2025

Name, Address, and County of Licensee Investigated:
The Villas at New Brighton
825 1st Ave NW
New Brighton, MN 55112
Ramsey County

Facility Type: Nursing Home

Evaluator's Name:
Jana Wegener, RN, Special Investigator

Finding: Substantiated, individual 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 resident was neglected when 2 alleged perpetrators (AP1 and AP2) failed to properly secure a lift sling prior to transferring the resident using a full body mechanical Hoyer lift. The resident fell and sustained a femur fracture requiring surgical repair and hospitalization.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. AP1 and AP2 were responsible for the maltreatment. Video footage from the incident showed the APs failed to ensure the sling loop was properly connected to the hook of the Hoyer spreader bar prior to moving the resident. The sling loop detached from the hook causing the resident to fall out of the Hoyer sling onto the floor from a suspended height of approximately 3-4 feet. The resident was transferred to the emergency department (ED), where it was identified he sustained a femur fracture requiring surgical repair and hospitalization.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family. The investigation included review of the resident record(s), hospital records, facility internal investigation, facility incident reports, personnel files, staff schedules, related facility policy and procedures, and previous federal investigation documentation.

The resident resided in a skilled nursing facility with diagnoses including hemiplegia hemiparesis (paralysis affecting one side of the body) following a stroke, and muscle weakness.

The resident's plan of care indicated the resident was totally dependent on 2 staff assistance for mobility and transfers using a full body mechanical Hoyer lift. The plan of care indicated the resident was at a risk for falls due to impaired mobility and poor safety awareness. The plan of care indicated staff should explain what they are going to do and provide cares in a gentle, unrushed, and thorough manner.

The resident's service delivery of care record the day of the incident indicated AP1 documented the resident was totally dependent on 2 staff for transfer assistance from surface to surface.

A facility training and skills competency form for operating the Hoyer full body mechanical lift included step-by-step instructions for completing a safe transfer per manufacturers guidelines. Step #7 indicated staff should attach the sling to the lift assuring that the loops are secured to the hooks.

The manufactures guidelines and instructional video resources reviewed for the Hoyer lift used at the time of the incident instructed users to place the straps of the Hoyer sling loops over the hooks of the spreader bar. The video instructed to always make sure the sling loops were secured into the spreader bar hooks and indicated staff should watch as the patient was raised to ensure safety.

A nurse's progress note the day of the incident indicated two staff members (AP1 and AP2) were in the resident's room getting him ready for a shower. The note indicated according to the APs, the resident was in the Hoyer sling to be transferred to the shower chair when one part of the sling came out of the Hoyer hook and the residents right leg slid out of the sling and the resident landed on the floor. The note indicated 911 was called and the resident was transferred to the ED.

A facility incident report and facility investigation indicated the resident fell from the Hoyer while being transferred from his bed to a shower chair with assist of 2 staff (AP1 and AP2). The incident report indicated a loop of the sling came off the Hoyer causing the residents leg to slip out of the sling and rest of the resident's body followed. The resident was sent to the ED and found to have a femur fracture. The facility investigation indicated when interviewed AP1 stated the sling loop came off the Hoyer lift when AP1 and AP2 had the resident hanging in the air. AP1 stated the sling loop did not rip or tare but detached from the corner of the hook. AP1 stated

the resident was suspended in the air for a brief period then the loop suddenly gave away. The facility investigation indicated AP2 stated she assisted AP1 to attach the resident's sling to the Hoyer lift hooks then one of the sling loops slipped and the resident fell on the floor. The facility investigation indicated the family member stated the video from the resident's room at the time of the incident showed the sling strap was not properly connected to the Hoyer causing it to come loose and the resident fell.

A review of the AP's personnel files lacked documentation of any other similar incidents previously.

AP1's personnel files included a disciplinary action form signed by AP1 following the incident. The form indicated AP1 received disciplinary action for a performance issue when a resident in AP1's care fell resulting in injury while being transferred with a Hoyer lift. The form indicate upon investigation it was determined that the sling was not properly secured prior to the lift being activated, which led to a loop on the sling becoming unhooked. The form indicated AP1 did not follow all safety and operational procedures when utilizing the Hoyer lift to assist the resident as directed in his plan of care. The form indicated AP1 received education to follow all procedures to ensure all steps are properly completed before utilizing a Hoyer lift. The form indicated AP1 should remind the second staff to also check and ensure everything was connected properly before beginning the transfer.

AP2's personnel files included a disciplinary action form signed by AP2 following the incident. The form indicated AP2 received education on using a Hoyer lift properly and completing a second check on the hooks and loops of the Hoyer lift. The form indicated AP2 should double check the hooks and loops connected to the Hoyer before transferring a resident.

A review of the videos provided by the resident's family showed AP1 and AP2 on either side of the bed. The Hoyer sling appeared to be connected to the Hoyer spreader bar hooks as AP1 raised the resident off the bed. Neither AP1 nor AP2 were observed check to ensure the sling was properly connected prior to moving the resident off the bed. Then, AP1 pulled the Hoyer away from the bed with the resident suspended 3-4 feet in the air, turned slightly, and at that point the right lower sling loop was clearly visible on top of the spreader bar hook, but was not secured inside the hook as manufactures and facility guidelines indicated. Then, the loop detached off the top of the hook causing the resident to fall onto the floor from a suspended height of approximately 3-4 feet. The resident landing on his right side and cried out in pain.

The resident's hospital record indicated the resident sustained a closed left subtrochanteric femur fracture after falling about 3 feet to the ground from a Hoyer lift during a transfer with facility staff. The record indicated the resident required surgical repair (internal fixation) to repair the resident's left femur fracture.

When interviewed facility leadership stated all staff including AP1 and AP2 were trained and competency tested on using the Hoyer lifts at the time of hire and in November 2025, prior to

the incident, when the new Hoyer lifts were implemented by the facility. Nursing leadership stated when she observed the video from the incident it showed the resident was not properly connected to the Hoyer prior to staff moving the resident. Nursing leadership stated AP1 and AP2 failed to ensure the sling strap loop was all the way into the hook before moving the resident. Nursing leadership stated both AP1 and AP2 should have double checked before moving the resident.

During a previous federal investigation interview, after watching the video from the fall incident, nursing leadership stated AP1 and AP2 did not following manufactures instructions for proper sling attachment during the transfer. Nursing leadership stated AP1 and AP2 incorrectly placed the right lower sling loop at the top of the hook instead of inside the lower part of the hook resulting in the loop detaching from the hook, which caused the resident to fall to the floor.

When interviewed the lift manufacturer customer service representative stated staff should ensure the sling loops are properly connected into the hook of the spreader bar, once attached, they should make sure it is correctly secured. The representative stated it would not be safe to move the resident if the loop was on top of the hook and indicated it would not be connected properly or fully secure in the loop and could fall off the hook.

When interviewed AP1 stated the night of the incident they were short staffed causing her to be under significant stress which she felt contributed to her being distracted the night of the incident. However, a review of the facility staffing schedules from the day of the incident and email communication with facility leadership failed to indicate there were any staffing issues or shortages the day of the incident as indicated by AP1. AP1 stated she connected the sling loops to the hooks of the Hoyer and lifted the resident off the bed then pulled him away from the bed. AP1 stated she normally watched all 4 loops and hooks like a hawk when a resident was first lifted off the bed to make sure things were connected properly and everything looked ok before moving a resident, but admitted she did not do so at the time of the incident. AP1 stated AP2 was there as the second pair of eyes but AP2 also did not notice the loop was not connected properly to the hook. AP1 stated she was watching the resident, but did not ensure the sling loops were securely connected to the Hoyer before moving the resident.

AP2 stated the day of the incident she helped hook the resident sling loops up to the Hoyer and indicated she was looking at the shower chair and moved to bring the chair closer when the sling loop fell off and the resident fell on the floor. AP2 stated she did not recall checking to ensure the loops were connected properly to the Hoyer hooks, and indicated she should have checked.

When interviewed the resident’s family member stated the video from the incident it showed the loop of the sling was placed on top of the hook and not connected to the Hoyer properly. The family member stated although the resident physically had returned to his baseline prior to

the incident, he was traumatized by the pain he experienced as a result of his injury and had difficulty trusting caregivers following 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: N/A
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The facility called 911, transferred the resident to the ED for evaluation/treatment, and lift was removed from service and inspected. AP1 and AP2 were suspended pending a facility investigation. All staff including AP1 and AP2 received re-education and completed competency testing on safe transfers using a full body Hoyer mechanical lift.

Action taken by the Minnesota Department of Health:
MDH previously investigated the issue during a standard abbreviated survey under 42 CFR 483, Subpart B, Requirement for Long Term Care Facilities, 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

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.

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

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to

the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Ramsey County Attorney
Ramsey City Attorney
New Brighton Police Department
Department of Human Services (DHS)
Nurse Aide Registry

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **11/19/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAS AT NEW BRIGHTON	**825 FIRST AVENUE NORTHWEST , NEW BRIGHTON, Minnesota, 55112**

(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 #H51646303M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. The following correction order is issued/orders are issued for #H51646303M, tag identification 21850.	20000		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **11/19/2025**

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THE VILLAS AT NEW BRIGHTON	**825 FIRST AVENUE NORTHWEST , NEW BRIGHTON, Minnesota, 55112**

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20000	Continued from page 1 The facility has agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul .htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "reviewed" in the box available for text. Then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.	20000		
21850	Patients & Residents of HC Fac.Bill of Rights CFR(s): MN St. Statute 144.651 Subd. 14 Subd. 14. Freedom from maltreatment. Residents shall be free from maltreatment as defined in the Vulnerable Adults Protection Act. "Maltreatment" means conduct described in section 626.5572, subdivision 15, or the intentional and non-therapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. Every resident shall also be free from non-therapeutic chemical and physical restraints, except in fully documented emergencies, or as authorized in writing after examination by a resident's physician for a specified and limited period of time, and only when necessary to protect the resident from self-injury or injury to others. This LICENSURE REQUIREMENT is NOT MET as evidenced by: The facility failed to ensure one of one resident(s) reviewed (R1) was free from maltreatment. The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and individual persons were responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	21850		