

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H54453268M
Compliance #: H54451783C

Date Concluded: August 13, 2026

Name, Address, and County of Licensee

Investigated:

Shakopee Friendship Manor
1340 3rd Avenue West
Shakopee, MN, 55379
Scott County

Facility Type: Nursing Home

Evaluator's Name: Angela Vatalaro, 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 facility staff neglected the resident when staff failed to properly transfer the resident using a mechanical lift. As a result, the resident fell.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined neglect was substantiated. Alleged perpetrators (AP) #1 and AP #2 were responsible for the maltreatment. Although AP #2 should not have operated the mechanical lift due to age restriction, both AP #1 and AP #2 failed to ensure all four points of the resident's sling were secured to the mechanical lift device during the transfer. As a result, the resident fell and sustained a shoulder fracture, head laceration, and bruises.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident record, facility internal investigation, video footage, personnel files, staff schedules, related facility

policy and procedures, and Minnesota Department of Health (MDH) previous survey complaint investigation notes.

The resident resided in nursing home. The resident's diagnoses included Alzheimer's disease. The resident's care plan indicated the resident was a total assist for transfers of two-staff using a mechanical lift (battery operated device requiring use of a sling attached to four hooks on a hanger bar). The resident's assessment indicated the resident had severe cognitive impairment and was dependent on staff for chair/bed-to-chair transfers.

A staff care sheet indicated the resident required assistance of two-staff using a mechanical lift.

Prior to the incident, the resident's record indicated the resident's transfers were observed by licensed nurses on bath days. The last observed transfer occurred a week prior to the incident. No issues were identified. In addition, there were no issues identified on other bath days.

Federal Fair Labor Standards Act prohibits workers under the age of 18 from operating or helping to use hazardous power-driven and mechanical equipment, including hoisting equipment.

The staff schedule indicated on the day and time of the incident in the resident's unit, AP #1 worked from 5:30 a.m. to 2:00 p.m. and AP #2 worked 5:30 a.m. to 2:00 p.m. AP #2 was identified by highlighted name as under the age of 18.

A review of other days of daily staff schedules indicated staff under the age of 18 were identified by highlighted name as a facility practice.

The facility's internal investigation indicated there were two staff members in the room (AP #1 and AP #2) for the resident's transfer. The staff members only hooked three of the four straps of the sling, did not observe this oversight, and went through with the transfer. This resulted in the resident falling out of the sling with her head and shoulder landing onto the floor.

Video clips and footage showed a camera was pointed down from the resident's head of bed and the following was observed:

AP #1 was on the left side and AP #2 was on the right side. A tan colored sling was positioned under the resident. AP #2 attached both the upper and lower points on the right side, AP #1 attached the upper loop to the hanger on the left side, however, did not attach the lower (leg) point. AP #2 walked around the bed to the side with the lift controls; AP #1 stood in the middle of the room. AP #1 and AP #2 were heard conversating aloud while the resident waited in the attached sling with her hands crossed.

AP #2 stood at the controls of the mechanical lift and used it to raise the resident up from the bed. Neither AP #1 nor AP #2 were seen to double check the attachment points to ensure the

sling was correctly attached as the left lower hanger attachment point did not have a sling loop secured on it. As the device was raised up with the resident inside, AP #2 turned away from watching the resident as the resident was raised and conversed with AP #1 who was back in the middle of the room doing other tasks. Neither AP #1 nor AP #2 had a physical hand on the resident as she was raised from the bed. The metallic hanger on the mechanical lift was seen to immediately turn from parallel to perpendicular to the bed as the resident was lifted.

AP #2 raised the resident up from the bed and AP #2 pulled the resident off the bed surface by pulling the mechanical lift away from the bed and into the middle of the room. AP #1 came to the beside and grabbed the resident's feet as the resident was being lifted away from the bed. The resident was seen in the air and immediately fell out of the sling onto the floor on her right side.

The resident's progress notes indicated the resident had fallen out of the mechanical lift and two staff (AP #1 and AP #2) were present at the time of the fall. The resident was found lying on the floor with one aide (AP #2) holding up her head and shoulders to support her head. Her legs were still in the mechanical lift sling. The resident was disconnected from the lift, and her legs were lowered to the ground. The resident was in mid-transfer from the bed to wheelchair. The nurse assessed the resident. The resident had a right-side bleeding head laceration which was cleansed. Steri-strips and dressing were also applied. The resident had right arm and elbow pain, grimaced and stated "ouch" "ouch" with arm movement. The resident declined to go to the hospital. In addition, the resident had a bruise on her right elbow and a bruise to her upper arm which was tender to the touch, swollen, and firm. The resident's provider was updated and an x-ray was ordered.

Radiology result records indicated the resident diagnosed with an acute (sudden) right shoulder fracture.

AP #1's personnel file records indicated AP #1 failed to follow facility protocol on mechanical lift transfer safety. Training records indicated AP #1 watched videos on mechanical lifts during her orientation, as well completed competency test out on this after she turned 18. Records indicated AP #1 received education and was signed off to "double check" to see if the Hoyer (mechanical lift) sling was hooked properly.

AP #2's personnel file records indicated AP #2 failed to follow facility protocol for the resident's mechanical lift transfer. Training records indicated AP #2 watched videos on mechanical lifts during her orientation, however, did not have competency test out on this as she was not age 18. Records prior to the incident indicated AP #2 received education and was signed off to "double check" to see if the Hoyer (mechanical Lift) sling was hooked properly.

During a previous MDH onsite complaint investigation survey interview, AP #1 stated she was present when the resident fell from the lift and had received education prior to the incident. AP #1 stated she missed securing the loop to the hanger when the resident was transferred. The

resident's wheelchair needed to be moved to complete the transfer, got distracted, and forgot to attach it. AP #1 then "assumed" AP #2 had noticed it and attached it prior to lifting the resident up in the machine. AP #1 verified they never re-checked the loops to ensure they were secured prior to the transfer and expressed "I should have." AP #2 stated herself and AP #1 "were not really paying attention" to the transfer. AP #2 verified she was under the age 18 and using the machine like they were doing on the day of the incident was "not something were supposed to do." When asked why she used the machine and not the other staff present AP #2 responded "I really have no reason why." AP #2 stated they would not double check the straps because they had just attached them. AP #2 stated someone should have double checked the loops and had physical contact with the resident.

During an interview, an unlicensed personnel stated there were four points to hook up a sling for the mechanical lift. Two points were near the head, and two points were at the legs which got criss-crossed. All four straps need to be attached and secured to the hanger. If a staff member was under age 18, they could only be the second person for assist. The adult would attach all the straps and operate the machine. The under age 18 staff member would guide a resident's body. During the transfer, both staff double check to ensure the straps were secure and connected into the hanger. The unlicensed personnel stated this has been the process at the facility for years.

During an interview, nurse #1 stated she was notified when the resident fell out of the mechanical lift. Upon arrival, the resident's leg was still attached in the lift sling. AP #2 was at the resident's head. The resident's head was bleeding and her right arm hurt. They got the resident back into bed. The resident declined going to the hospital for evaluation. AP #2 was under the age of 18. If staff were under age 18, staff were shown how to operate the lift, however they are not allowed to use, operate or push buttons until they were 18 years old. The daily schedule identified which staff members were under age 18 and was highlighted in blue.

During an interview, nurse #2 stated if staff were under the age of 18, they were allowed to be second person with a 2-person transfer using a mechanical lift and only guide the resident's body in the sling. They were not allowed to push buttons or run machines.

During an interview, nurse #3 stated she watched the video clips and footage of the resident's fall. AP #1 and AP #2 did not do a safe transfer. Nurse #3 stated both AP #1 and AP #2 did not double check to ensure all four sling straps were hooked. Both were responsible for ensuring straps were attached. AP #1 who was the adult should have been the only one attaching all four straps, operating the machine, and would be expected to double check to ensure all were attached. AP #2 who was under age 18, should not have operated the machine nor attach any straps. However, AP #2 as a second assist, would be the second set of eyes to visually double check the straps. AP #2 knew how to attach and push the buttons on the lift because she had been a second assist prior, watched enough transfers as a second assist, and during orientation watched videos on the machines. AP #2 had not been tested out on competency because she

was not 18 years old. AP #2 knew she was not supposed to operate or use the machine. Nurse #3 stated this was discussed in orientation as well as ongoing with staff during nurse meetings.

During an interview, nurse #4 stated the resident sustained a fracture, head laceration and bruising. Prior to the incident, the resident had been losing weight, was receiving comfort care, and admission to hospice services had been discussed. The resident passed away.

During an interview, AP #1 stated she was assigned to care for the resident the day of the incident. AP #1 called AP #2 into the room to assist with the transfer. AP #1 stated she did not double check all the sling loops prior to the transfer because in her “brain” when she went to grab the wheelchair the resident was not ready for the transfer. AP #1 also said AP #2 who was operating the machine, was not 18 years old. AP #1 stated at the time she did not know AP #2 was not 18, nor did it enter her mind that AP #2 was not 18 and could not operate the lift. AP #1 said AP #2 just took initiative to operate the machine, so AP #1 then took initiative to become the second person to assist. AP #1 stated the daily schedule was posted and staff under age 18 were highlighted.

During an interview, AP #2 stated how she double checked the straps by attaching them. AP #2 stated she attached her side of the sling straps (right side). At the time of the incident AP #2 stated she was not 18. AP #2 stated if you were under age 18 you cannot operate the machine. AP #2 stated she tried to remember to double check the straps to ensure they were connected. AP #2 stated daily schedules were posted and staff who were under age 18 were highlighted and had a star next to their name.

During an interview, a family member stated the resident had a pending hospice evaluation already scheduled prior to the resident’s fall from the mechanical lift.

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.

- (5) an individual makes an error in the provision of therapeutic conduct to a vulnerable adult that results in injury or harm, which reasonably requires the care of a physician, and:
- (i) the necessary care is provided in a timely fashion as dictated by the condition of the vulnerable adult;
 - (ii) if after receiving care, the health status of the vulnerable adult can be reasonably expected, as determined by the attending physician, to be restored to the vulnerable adult's preexisting condition;
 - (iii) the error is not part of a pattern of errors by the individual;
 - (iv) if in a facility, the error is immediately reported as required under section 626.557, and recorded internally in the facility;
 - (v) if in a facility, the facility identifies and takes corrective action and implements measures designed to reduce the risk of further occurrence of this error and similar errors; and
 - (vi) if in a facility, the actions required under items (iv) and (v) are sufficiently documented for review and evaluation by the facility and any applicable licensing, certification, and ombudsman agency.

Vulnerable Adult interviewed: No. The resident was deceased.

Family/Responsible Party interviewed: Yes.

Alleged Perpetrator interviewed: Yes.

Action taken by facility:

The licensed nurse responded to the resident's room, was assessed for injury and offered evaluation at a hospital. The facility removed AP #1 and AP #2 from operating machines for the remainder of the scheduled shift. The facility conducted an investigation. AP #1 and AP #2 no longer work at the facility.

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

Scott County Attorney

Shakopee City Attorney

Shakopee Police Department

Minnesota 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 07/30/2026	
NAME OF PROVIDER OR SUPPLIER SHAKOPEE FRIENDSHIP MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 1340 THIRD AVENUE WEST , SHAKOPEE, Minnesota, 55379			
(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 #H54453268M, 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 #H54453268M, tag identification 21850. The facility has agreed to participate in the			20000			

Office of Primary Care and Health Systems Management

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

Minnesota 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 07/30/2026	
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20000	Continued from page 1 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 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			