Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL205513969M
Compliance #: HL205513871C

Date Concluded: October 13, 2026

Name, Address, and County of Licensee Investigated:
Woodbury Estates
2825 Woodlane Dr
Woodbury, MN 55125
Washington County

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

Evaluator's Name:
Lacey Eggersdorfer, 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 alleged perpetrators (AP #1 and AP #2) neglected the resident when they improperly used a mechanical lift and the resident fell, fracturing her back.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. AP #1 and AP #2 were responsible for the maltreatment. Both AP #1 and AP #2 were trained in using mechanical lifts and extension straps and failed to use the equipment safely. The incident resulted in injury to the resident when she fell from the mechanical lift.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident records, hospital records, facility internal investigation, facility incident reports, personnel files, staff schedules, related facility policy and procedures. Also, the investigator observed unlicensed staff transfer the resident during an onsite visit.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia and partial paralysis following a stroke. The resident's service plan included full assistance with mobility as well as mechanical lift transfers three times per day. The resident's assessment indicated she was disoriented at baseline and unable to walk.

An incident report indicated the resident was being transferred by AP #1 and AP #2 using a mechanical lift. The resident fell from the lift landing on her back. The sling the resident had been seated in had three of the four straps attached to the mechanical lift, and the fourth strap was not connected. The resident was assessed by facility nursing staff after the fall.

Internal investigation documents indicated the unconnected strap on the resident's sling was called an "extension strap" and was only to be used for transferring residents off the floor. The extension strap was improperly used for transferring the resident out of bed and not secured to the mechanical lift. The internal investigation indicated that the resident was transported to the hospital later that day for evaluation.

Medical records indicated the resident was found to have a fractured back as well as bruising to her left arm. Medical records also indicated the resident was admitted for her injuries and pain control.

Training documents indicated both AP #1 and AP #2 were trained in mechanical lifts two months prior to the incident. Training documents indicated that both AP #1 and AP #2 were able to demonstrate competency in using the mechanical lift.

Training videos reviewed by AP #1 and AP #2 indicated that the extension straps were neon yellow in color, while sling straps were black in color. Extension straps were only used in demonstrating transfers of residents from the floor following a fall.

In an interview, licensed staff stated AP #1 and AP #2 both were tested on the skill of using a mechanical lift and passed. The skill of using a mechanical lift requires at least two people. The resident should be lifted off the surface they are transferring from, and both people ensure the resident was secure prior to unlocking the wheels of the mechanical lift and moving the resident. Licensed staff stated it would be the responsibility of both people to stop the transfer if the resident suddenly became unsecure in the lift.

In an interview, AP #1 stated the neon extension strap was on the sling already when both her and AP #2 placed it under the resident and hooked it on the mechanical lift. She was aware that the extension strap was meant only for residents being transferred from the floor but did not see an issue with its securement until after she lifted the resident and started to move her. AP #1 stated she believed the strap became unsecure during the lift and caused the resident to fall.

In an interview, AP #2 stated she knew the extension strap was not normally used for transferring residents from bed. She did not check the securement of the straps to the mechanical lift hooks prior to the resident being lifted from the bed. AP #2 stated she turned to get to the other side of the resident during the lift, and at that moment the resident fell.

In an interview, a family member stated the resident has had ongoing back pain since the fall. The family member also stated he has had concerns about how staff used the mechanical lift in the past.

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: No, due to resident’s cognition.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes, AP #1 and AP #2.

Action taken by facility:
The facility immediately assessed the resident and sent her into the hospital for further evaluation.

Action taken by the Minnesota Department of Health:
The responsible party will be notified of their right to appeal the maltreatment finding.

The facility was found to be in 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

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

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Washington County Attorney
Woodbury City Attorney
Woodbury Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20551	A. BUILDING: _____ B. WING _____	C 09/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODBURY ESTATES	2825 WOODLANE DRIVE WOODBURY, MN 55125

(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 ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL205513591C/HL205513712M #HL205513871C/HL205513969M On 9/14/26, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 59 residents receiving services under the provider 's Assisted Living with Dementia Care license. The following correction order is issued for #HL205513591C/HL205513712M, and #HL205513871C/HL205513969M, tag identification 2360.	0 000		
02360	144G.91 Subd. 8 Freedom from maltreatment	02360		

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02360	Continued From page 1 Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure two of two resident reviewed (R1, R2) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility 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.	02360	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.	

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02360	Continued From page 2	02360	THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	