Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL201073502M
Compliance #: HL201076647C

Date Concluded: August 13, 2025

Name, Address, and County of Licensee Investigated:
Landings of Minnetonka
14505 Minnetonka Drive
Minnetonka, MN 55345
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name:
Maerin Renee, 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 facility neglected the resident when the resident experienced respiratory distress, and staff drove him to the emergency room in a private vehicle and left. Staff did not provide information to hospital staff before leaving other than the resident was short of breath. The resident's blood oxygen saturation level (O2 sat) was in the 50s (normal is 95-100%). The resident required a stay in the intensive care unit (ICU) and intubation.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. When providing cares, a staff member noticed the resident did not look well. The staff member checked the resident's vital signs, which were outside normal ranges. Staff recommended the resident go to the hospital for further evaluation, but initially the resident declined. The resident eventually agreed to go to the hospital, but only if a staff member drove him. A staff member drove the resident to the hospital, provided front desk staff with the resident's face

sheet and facility contact information, and returned to the facility once the resident was settled in the hospital emergency department (ED).

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

The resident resided in an assisted living facility. The resident's diagnoses included multiple sclerosis, chronic obstructive pulmonary disease (COPD), and schizoaffective disorder. The resident's/client's services included assistance with activities of daily living, meals, housekeeping, laundry, and medication management. The resident's assessment indicated he was able to understand others and make his needs known and he was independent with call system operation.

The resident's progress notes indicated after smoking, the resident complained of difficulty breathing and was taken to the hospital for further evaluation. A change in condition assessment was completed after the resident returned from the hospital seven days later.

The resident's hospital records indicated he had a history of COPD, obstructive sleep apnea (for which he used a CPAP machine), and tobacco use. The resident was admitted to the hospital for acute respiratory distress. On arrival to the ED, the resident presented with altered mental status, severe hypoxia (low blood oxygen), and hypercapnia (high levels of carbon dioxide in the blood). Labs revealed respiratory acidosis (a condition where the blood becomes too acidic due to excessive carbon dioxide buildup), and chest imaging showed multifocal pneumonia. The resident's respiratory panel was positive for influenza and COVID. The resident was started on BiPAP (a type of non-invasive ventilation to help with breathing) but progressed to acute respiratory failure requiring intubation and admission to the intensive care unit (ICU). The resident was successfully extubated three days later and transferred to the medical floor a day after that. Upon assessment, vital signs were stable, and oxygen saturation was 93% on room air. The resident was discharged back to the facility after seven days in the hospital.

When interviewed, a nurse said staff reported to her something was off about the resident. Staff took his vital signs, and his O2 sat was low. Staff recommended the resident go to the hospital, but the resident said he was fine and did not want to go to the hospital. Several staff members talked with the resident about going to the hospital, and then they called the nurse. The nurse said the resident then agreed to go to the hospital, but not in an ambulance. He wanted a staff member to drive him. The nurse said a staff member then drove the resident to the hospital and provided staff with the resident's face sheet and medication list, per protocol.

When interviewed, a staff said he saw the resident in the morning, and he looked "different." The staff took the resident's vital signs, which were outside normal range. The staff

recommended the resident go to the hospital, but the resident declined. After talking with other staff members, the resident agreed to go to the hospital, but only if a staff member drove him. The staff stated he drove the resident to the hospital and gave the residents face sheet and information to the front desk staff. After the resident was settled in the ED, the staff stated they returned to the facility.

When interviewed, the resident did not remember the hospitalization but said staff treated him well and he liked living at the facility. The resident said he used inhalers to manage his COPD.

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: Yes.
Family/Responsible Party interviewed: No, the resident is his own guardian.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
Staff assessed the resident appropriately and in a timely manner. After the resident returned from the hospital, his provider orders were followed as prescribed.

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
	20107	A. BUILDING: _____ B. WING _____	C 07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDINGS OF MINNETONKA	14505 MINNETONKA DRIVE MINNETONKA, MN 55345

(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 July 29, 2025 the Minnesota Department of Health initiated an investigation of complaint #HL201076647C/#HL201073502M. No correction orders are issued.	0 000	The Minnesota Department of Health documents the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule number out of compliance are listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings, which are in violation of the state statute after the statement, "This Rule 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/RULES.	