Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL282612160M
Compliance #: HL282618083C

Date Concluded: July 1, 2026

Name, Address, and County of Licensee Investigated:
The Glenn Minnetonka
5399 Woodhill Road
Minnetonka, MN 55345
Hennepin County

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

Evaluator's Name: Willette Shafer
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 alleged perpetrator (AP) neglected the resident when the AP failed to provide scheduled services per the resident's care plan. The resident fell and was not found until the following day.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The resident fell on her bathroom floor while getting ready for bed the night before. The resident had no scheduled services throughout the night until a safety check at 10:00 a.m. the following day. The AP was observed on a surveillance camera in the hallway close to the resident's apartment door around 10:00 a.m. The AP reported she checked on the resident, but her apartment door was locked, and the AP could not open the door. The AP knocked and did not hear anything. The AP thought the resident was out of her apartment for an activity as she frequently locked her door when she left her apartment. The AP found the resident three hours later on her apartment floor after she noticed the resident was not at lunch. The resident was sent to the hospital and diagnosed with rhabdomyolysis (breakdown on skeletal muscle). The resident

received treatment and then she was sent to a transitional care unit for continued recovery. The resident returned to the facility at her baseline health condition. The error was an isolated incident.

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 resident records, hospital records, facility internal investigation, facility incident reports, personnel files, staff schedules, pendant light reports, and related facility policy and procedures. Also, the investigator toured the facility and observed staff completing safety checks and resident care.

The resident resided in an assisted living facility. The resident's diagnoses included ataxia (lack of voluntary muscle coordination), muscle weakness, unsteady gait, and osteoporosis. The resident's service plan included assistance with bathing twice a week, monthly vitals, weekly housekeeping, and a daily safety check at 10:00 a.m. The resident was independent with all other care.

The internal investigation indicated the resident was found on her bathroom floor at 1:25 p.m. The resident was incontinent of urine and reported she fell while getting ready for bed around 8:00 p.m. the night before. The resident reported she pressed her pendant light (watch type pendant around her wrist) but it did not work. The resident complained of hip pain and was sent to the hospital. Upon further investigation, it was noted the resident had a scheduled safety check at 10:00 a.m. The AP reported she went to the resident's room at 10:00 a.m. but her door was locked, and she was unable to get in. While the AP looked for the resident, another resident requested assistance. When the resident failed to attend lunch, the AP went back to the resident's apartment and found her on the floor. The AP called a nurse for help. The resident complained of hip pain and was sent to the hospital.

The hospital record indicated the resident was diagnosed with acute hip pain, delirium, and traumatic rhabdomyolysis. The resident's imaging showed no fractures. She received treatment and was discharged to a transitional care unit for further recovery.

Video surveillance footage showed the AP went down the resident's hallway and enter another resident's room. The video stopped playing when no motion was detected. When motion was detected again, the AP was walking back up the hallway away from the resident's room. It was unclear if the AP went to the resident's door as the surveillance video was not recorded for a period.

During an interview, the resident said she fell while getting ready for bed. She tried to inch her way to the door but was too weak. She lay on the floor throughout the night, until staff found her the next day. She pressed her pendant light to call for assistance, but nobody came. She said her pendant light normally flashed red (demonstrated for investigator) when she pressed the button but during this incident, it did not.

During an interview, a family member said the facility called and reported the resident fell and discussed sending the resident to the hospital. At the hospital, the resident was weak, delirious, and was diagnosed with rhabdomyolysis. The resident was given fluids, monitored for a few days, and sent to a transitional care unit for further rehabilitation. No fractures were noted on her imaging. She said the resident locked her door at night and when she left her apartment during the day.

During an interview, the nurse said the AP called and reported the resident was on the floor and needed assistance. When the nurse arrived, she said the resident appeared weak and reported she was on the floor for a long time. The nurse assessed vitals and called emergency services. She said the resident wore a pendant light on her wrist (watch pendant). The resident reported she pressed her pendant light, but it did not work. This was the first time she heard of a pendant not working properly. She reported the pendant issue to management.

During an interview, a member of management-1 said the resident was mostly independent. There were no scheduled services throughout the night for the resident. The resident's only service scheduled for that day was a 10:00 a.m. safety check. During the internal investigation the AP reported she checked on the resident around 10:00 a.m. but the resident's door was locked, and the AP was unable to open the apartment door. The AP knocked on the resident's door but did not hear anything. The AP went to look for the resident or find someone to open the resident's door but became distracted by another resident who needed assistance. Member of management-1 viewed the surveillance footage. The surveillance video showed the AP at the resident's apartment door during the resident's scheduled safety checks.

During an interview, the AP said she went to the resident's room during her scheduled safety check at 10:00 a.m. but the resident's door was locked. She knocked on the door and yelled for the resident but never heard anything. She thought the resident was out of her apartment because the resident usually locked her door when she left her apartment. The AP said she was on her way to get a master key to open the resident's apartment door when another resident requested toilet assistance. She helped the other resident and forgot to go back and check on the resident. When she noticed the resident was not at lunch, the AP went to the resident's apartment and found her lying on the floor. She called a nurse for assistance, and the resident was sent to the hospital. She said the day was very busy as another resident returned from the hospital and required extra care. She expressed remorse for forgetting to go back to the resident's room.

The low battery report indicated there were no issues with the resident's pendant battery. However, on the day the resident fell the pendant light report indicated "missing device."

During an interview, a member of management-2 said she received the low battery report every morning along with the receptionist. The receptionist received the report on the weekends and would call or text when a resident needed a battery replaced. According to management-2,

when a resident's pendant indicated low battery the facility had five days to change the battery before the pendant stopped working. A resident's pendent indicated "missing device" when a resident was out of the building. Once the resident returned to the building, the system detected the pendant again was not on the report the following day. At times a resident's pendant showed up on the report as "missing device" even when the resident was in the building. Facility staff tested those pendants and the pendants alerted when the button was pressed.

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: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility completed an internal investigation and completed re-education with staff members. The facility addressed call pendant issue and adjusted processes.

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
	28261	A. BUILDING: _____ B. WING _____	C 06/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GLENN MINNETONKA	5300 WOODHILL ROAD 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 June 3, 2026, the Minnesota Department of Health initiated an investigation of complaint #HL282618083C/#HL282612160M. No correction orders are issued.	0 000		