Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL304741180M
Compliance #: HL304745322C

Date Concluded: April 27, 2026

Name, Address, and County of Licensee Investigated:
Deephaven Woods Senior Living
18025 Minnetonka Boulevard
Deephaven, MN 55391
Hennepin County

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

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 she fell and layed on the floor for over four hours before staff found her. She was hospitalized and diagnosed with a femur and hip fracture.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Staff followed the resident's plan of care at the time of the incident. When staff found the resident on the floor of her room, they immediately notified a nurse, contacted 911, who transported the resident to the hospital for further evaluation. The resident was diagnosed with a left femoral neck fracture and was expected to return to her previous level of functioning.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted family and the hospital. The investigation included review of the resident record, hospital records, facility internal investigation documentation, facility incident reports, video footage, personnel files, staff

schedules, and related facility policy and procedures. Also, the investigator observed staff cares and interactions with residents.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia. The resident's services included verbal cueing with activities of daily living (ADLs), meals, and medication management. The resident's assessment indicated the resident was unable to make good decisions for self-preservation and wandered or acted impulsively. The resident's gait and balance were assessed as normal.

Upon admission to the facility's memory care unit, nursing assessed the resident as independent with many activities including getting into and out of bed, walking, eating, grooming, and toileting. The resident's signed service plan indicated staff provided verbal cues and set-up for activities including showering, dressing, and oral care. Routine safety checks were ordered twice a day, at lunch and dinner time.

An incident report indicated a staff member entered the resident's room one morning and found her on her bathroom floor. The resident's pants were at her ankles, and her shoes were next to her bed. The resident could not recall how she fell or whether she hit her head. The resident's cognition was at baseline, but she complained of severe pain in her left foot and could not move it. The staff member notified a nurse, who instructed the staff member to call 911. EMS transported the resident to the hospital for further assessment.

Hospital records indicated the resident was diagnosed with a left femoral neck fracture. The fracture was successfully repaired via surgical intervention. After a 3-day hospital stay the resident admitted to a transitional care unit (TCU) for managed recovery and then moved to a new facility.

When interviewed, a supervisor said the resident was independent with most ADLs, including toileting and walking. The resident was unable to use the call system (pendants), so her needs were met by her service plan. The resident's services included verbal cueing and reminders, and safety checks twice a day. Staff also checked on the resident while providing cares and reminders. One morning staff entered the resident's apartment and found her on her bathroom floor. It appeared she tried to get up to go to the bathroom at some point and had either lost her balance or tripped on a pant leg. Staff notified a triage nurse, who instructed her to call 911. EMS personnel transported the resident to the hospital via ambulance.

When interviewed, family members said they were disappointed by the care the resident received while she lived at the facility. Family members described staff as rude and inattentive toward the resident and that they lacked a basic level of dementia-care comprehension. The family members believed the resident was supposed to receive safety checks every two hours and that the frequency of safety checks was changed without their consent. After her recovery at the TCU, the resident experienced cognitive decline but returned to her previous level of

functioning. When the resident was discharged from the TCU, the family chose to move her to another facility.

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: No, unable due to cognitive impairment.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility completed an investigation and reviewed the resident’s service plan.

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
	30474	A. BUILDING: _____ B. WING _____	C 03/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEEPHAVEN WOODS SENIOR LIVING	18025 MINNETONKA BOULEVARD DEEPHAVEN, MN 55391

(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 March 10, 2026, the Minnesota Department of Health initiated an investigation of complaint #HL304745322C/#HL304741180M. No correction orders are issued.	0 000	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. 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.	