Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Project: HL346629903M
Compliance Project: HL346624780C

Date Concluded: April 22, 2026

Name, Address, and County of Licensee Investigated:
Havenwood of Minnetonka
17710 Old Excelsior Blvd
Minnetonka, MN 55345
Hennepin County

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

Evaluator's Name: Lisa Coil, RN, BSN
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(s) (AP1 and AP2) neglected the resident when AP1 and AP2 failed to provide toileting to the resident. The resident fell and fractured his wrist and hip.

Investigative Findings and Conclusion: The Minnesota Department of Health determined neglect was not substantiated. While it was true the resident fell and sustained an injury, AP1 and AP2 took appropriate steps to get help when the resident was found on the floor and activated emergency medical services.

The investigator conducted interviews with facility staff members, including administrative staff, and unlicensed staff. The investigator contacted the residents family. The investigation included review of the resident record, facility internal investigation, facility incident reports, personnel files, staff schedules, and video surveillance.

The resident resided in an assisted living memory care unit. The resident's diagnoses included seizures, dementia, and repeated falls. The resident's service plan indicated the resident needed verbal cues but did not need physical assistance and was at risk for falls. The resident's assessment indicated the resident has occasional disorientation, difficulty with remembering and using information.

The facility's incident report indicated the resident was found on the floor early one morning. The report indicated staff called the triage nurse to report the fall and the resident had a left hip and left wrist fracture. The triage nurse told the staff to call 911. The report indicated emergency medical services arrived and transported the resident to the hospital.

During an interview, AP1 stated AP2 called for assist for a resident who had fallen on the floor. AP1 stated AP2 asked her to check the residents vital signs (blood pressure, pulse, temperature) and AP1 agreed. AP1 stated she called the nurse on duty and called 911. AP1 stated the resident was somewhat oriented, like he knew what he wanted to say but could not get the words out; however, the resident was able to say he broke his hip and did not want to be touched.

During an interview, AP2 stated the resident's call light was going off so he answered the light and found the resident on the floor. AP2 stated the resident complained of pain on his left side but would not let AP2 touch him. AP2 stated he tried to put a pillow behind the resident's head, but the resident refused it. AP2 stated he called his co-worker [AP1] for help. AP2 stated AP1 took the residents vital signs and called the nurse to report the fall. AP2 stated emergency medical services was called and the resident was taken to the hospital.

During an interview, the family member stated prior to admission to the facility the resident started having seizures and had some falls at home. The resident was hospitalized and diagnosed with Lewy body dementia. Following the residents hospitalization the resident admitted to the facility. The family member indicated the resident had a good experience the first day at the facility but had a fall within about 18 hours of admit, resulting in a left hip and left wrist fracture. The family member stated the resident had partial hip replacement surgery and was moved to a rehabilitation facility. The family member stated the resident was ready to return to the facility but unfortunately fell at the rehabilitation facility and fractured his sacrum and a knuckle, prolonging his stay at the rehabilitation facility.

During an interview, a manager stated the facility does not have a fall policy, they have an incident report policy. The manager stated caregivers were to enter the initial fall incident information into the electronic medical record and the nurse would complete the remaining information. The manager stated the electronic medical record takes staff step by step to complete the incident. The manager also stated at the time of this incident, the process was changing to caregivers entering the initial fall information on paper documents and giving it to the nurse.

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, resident was not interview due to disorientation.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility: The facility sent the resident to the hospital and investigated the incident.

Action taken by the Minnesota Department of Health: 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34662	A. BUILDING: _____ B. WING _____	C 03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVENWOOD OF MINNETONKA	17710 OLD EXCELSIOR BOULEVARD MINNETONKA, MN 55345

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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: #HL346624780C / /#HL346629903M On March 18, 2026, 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 53 residents receiving services under the provider ' s Comprehensive Assisted Living license. The following correction order is issued/orders are issued for #HL346624780C / /#HL346629903M, tag identification 0450 and 1480.	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.	
0 450 SS=F	144G.41 Subdivision 1 Minimum requirements All assisted living facilities shall:	0 450		

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0 450	Continued From page 1 (1) distribute to residents the assisted living bill of rights; (2) provide services in a manner that complies with the Nurse Practice Act in sections 148.171 to 148.285; (3) utilize a person-centered planning and service delivery process; (4) have and maintain a system for delegation of health care activities to unlicensed personnel by a registered nurse, including supervision and evaluation of the delegated activities as required by the Nurse Practice Act in sections 148.171 to 148.285; This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to utilize a person-centered planning and service delivery process when the license failed to identify or implement fall interventions to prevent future falls for 3 out of 4 residents (R2, R3, and R4) reviewed. The fall prevention plans show a pattern of the same non-individualized interventions from resident-to-resident nor do the plans demonstrate individualization after most falls have occurred. This practice resulted in a level two violation (a violation that did not harm a client's/resident's health or safety but had the potential to have harmed a client's/resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of clients/residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include:	0 450		

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0 450	Continued From page 2 R2 R2's diagnoses included memory difficulties following a brain bleed and Diabetes. The service plan also indicated R2 had poor judgement, had difficulty remembering and using information, and was only oriented to self. R2's service plan dated October 15, 2025, indicated R2 was at risk for falls, used a wheelchair for mobility, and required staff assist with transfers. The plan indicated the facility listed fall interventions which included private duty nurse, and physical and occupational therapy evaluation and treat as needed. The same document indicated the interventions directed towards the facility's unlicensed personnel (ULP) included: " Raised toilet seat/shower chair, " Ensure adequate lighting is used " Keep room free of clutter " Keep personal items close " Use proper footwear " Encourage activities of choice " Encourage use of assistive device " Educated and encouraged to use call pendant " Use of transfer pole for transfers An incident/occurrence report indicated R2 fell on October 20, 2025, at 1:06 a.m., R2 fell from his bed. The occurrence note indicated "recommendations shown are based on setup as of the assessment completion date." A review of the medical record identified no new person-centered interventions regarding reducing risk for falls afterwards.	0 450		

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0 450	Continued From page 3 An incident/occurrence report indicated on November 13, 2025, at 9:45 p.m. R2 was found on his knees in front of his wheelchair. A review of the medical record identified no new person-centered interventions regarding reducing risk for falls afterwards. An incident/occurrence report indicated on November 15, 2025, at 11:15 p.m. R2 was found on the floor. A review of the medical record identified no new person-centered interventions regarding reducing risk for falls afterwards. An incident/occurrence report indicated on November 22, 2025, at 8:45 a.m. R2 was found on the floor. A review of the medical record identified no new person-centered interventions regarding reducing risk for falls afterwards. An incident/occurrence report indicated on January 12, 2025, at 5:45 a.m. R2 was found on the floor. The occurrence note indicated "recommendations shown are based on setup as of the assessment completion date." R2's updated service plan dated January 12, 2026, indicated fall interventions were updated to include the following: " Ensure R2 had shoes with soles " Keep within sight when sleeping " Request physical therapy/occupational therapy to evaluate and treat " Request a Halo transfer pole for transfers	0 450		

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0 450	Continued From page 4 A review of R2's updated service plan dated February 15, 2026, did not identify changes regarding fall interventions. R3 R3's diagnoses included muscle weakness and repeated falls. The care plan also indicated R3 makes unsafe or inappropriate decisions, can be forgetful. R3's service plan dated December 31, 2025, indicated R3 was at risk for falls, required staff assist with ambulation, and required the use of a gait belt when transferring or ambulating. The same document indicated the interventions directed towards the facility's unlicensed personnel (ULP) included: " Raised toilet seat/shower chair, " Ensure adequate lighting is used, " Keep room free of clutter " Keep personal items close and " Use proper footwear " Encourage activities of choice. " Encourage use of assistive device " Educated and encouraged to use call pendant, " Train staff on proper transferring and lifting An incident report indicated on January 3, 2026, at 10:00 a.m., R3 fell from his bed. The occurrence note indicated "recommendations shown are based on setup as of the assessment completion date." A review of the medical record identified no new person-centered interventions regarding reducing risk for falls afterwards. An incident report indicated on January 3, 2026,	0 450		

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0 450	Continued From page 5 at 8:00 p.m., R3 fell from his bed. The occurrence note indicated "recommendations shown are based on setup as of the assessment completion date." A review of the medical record identified no new person-centered interventions regarding reducing risk for falls afterwards. R3's updated service plan dated January 9, 2026, indicated one update to the service plan which was to perform safety checks and monitor for safety and the resident refused them. An incident report indicated on January 10, 2026, at 10:45 a.m., R3 was found on the floor. The occurrence note indicated "recommendations shown are based on setup as of the assessment completion date." A review of the medical record identified no new person-centered interventions regarding reducing risk for falls afterwards. An incident report indicated on January 14, 2026, at 10:30 p.m., R3 was found on the floor. The occurrence note indicated "recommendations shown are based on setup as of the assessment completion date." A review of the medical record identified no new person-centered interventions regarding reducing risk for falls afterwards. An incident report indicated on January 16, 2026, at 11:15 p.m., R3 was found on the floor. The occurrence note indicated "recommendations shown are based on setup as of the assessment completion date."	0 450		

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0 450	Continued From page 6 A review of the medical record identified no new person-centered interventions regarding reducing risk for falls afterwards. An incident report indicated on January 29, 2026, at 8:00 p.m., R3 was found on the floor. The occurrence note indicated "recommendations shown are based on setup as of the assessment completion date." A review of the medical record identified no new person-centered interventions regarding reducing risk for falls afterwards. An incident report indicated on February 3, 2026, at 7:30 p.m., R3 was found on the floor. The occurrence note indicated "recommendations shown are based on setup as of the assessment completion date." A review of the medical record identified no new person-centered interventions regarding reducing risk for falls afterwards. An incident report indicated on February 5, 2026, at 7:00 p.m., R3 was found on the floor. The occurrence note indicated "recommendations shown are based on setup as of the assessment completion date." A review of the medical record identified no new person-centered interventions regarding reducing risk for falls afterwards. R4 R4's diagnoses included Alzheimer's. The care plan also indicated R4 makes unsafe decisions, needs supervision, is unable to remember or use information, is frequently disoriented.	0 450		

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0 450	Continued From page 7 R4's service plan dated November 13, 2026, indicated R4 was at risk for falls, and required staff assist with ambulation. The same document indicated the interventions directed towards the facility's unlicensed personnel (ULP) included: " Raised toilet seat/shower chair, " Ensure adequate lighting is used, " Ensure room is clean and tidy " Keep personal items close, and " Use proper footwear " Encouraged activities of choice " Encouraged use of assistive devices " Complete wellness checks " Train staff on proper transferring and lifting. An incident report indicated on December 5, 2025, at 9:00 a.m., R4 had a fall. The occurrence note indicated "recommendations shown are based on setup as of the assessment completion date." A review of the medical record identified no new person-centered interventions regarding reducing risk for falls afterwards. An incident report indicated on January 14, 2026, at 8:45 p.m. R4 fell to floor while trying to stand up alone and had a bump on her head. lost his balance and fell while walking. The occurrence note indicated "recommendations shown are based on setup as of the assessment completion date." A review of the medical record identified no new person-centered interventions regarding reducing risk for falls afterwards.	0 450		

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0 450	Continued From page 8 An incident report indicated on January 21, 2026, at 2:41 p.m. R4 was found on the floor and complained of pain to her hip. A review of the medical record identified no new person-centered interventions regarding reducing risk for falls afterwards. An incident report indicated on January 23, 2026, at 1:35 p.m. R4 was found on the floor. An incident report indicated on January 29, 2026, at 9:50 p.m. R4 was found on the floor. The occurrence note indicated "recommendations shown are based on setup as of the assessment completion date." A review of the medical record identified no new person-centered interventions regarding reducing risk for falls afterwards. An incident report indicated on January 29, 2026, at 7:45 p.m. R4 fell from a Broda chair (a specialized seating chair to provide comfort, support, and mobility for individuals with limited mobility or specific health needs). A review of the medical record identified no new person-centered interventions regarding reducing risk for falls afterwards. An incident report indicated on R4's updated service plan dated February 11, 2026, indicated a fall intervention was added to include frequent checks to ensure the residents safety. An incident report indicated on February 18, 2026, at 8:15 p.m. R4 fell from a Broda chair. The occurrence note indicated "recommendations	0 450		

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0 450	Continued From page 9 shown are based on setup as of the assessment completion date." A review of the medical record identified no new person-centered interventions regarding reducing risk for falls afterwards. An incident report indicated on February 19, 2026, at 11:15 p.m. R4 was found on the floor. The occurrence note indicated "recommendations shown are based on setup as of the assessment completion date." A review of the medical record identified no new person-centered interventions regarding reducing risk for falls afterwards. An incident report indicated on March 7, 2026, at 8:00 a.m. R4 was found on the floor. The occurrence note indicated "recommendations shown are based on setup as of the assessment completion date." R4's updated service plan dated March 12, 2026, indicated R4 was bed bound, bed should be kept in lowest position, fall mat in place, and wellness checks every two hours. Durning an interview on March 30, 2026, at 2:15 p.m., Executive Director (ED)-E stated intervention are documented on the service plan and on the Occurrence Note. The ED stated they try something new after a fall 95% of the time. The ED stated the licensee did not have a policy specific to falls. TIME PERIOD FOR CORRECTION: Seven (7) days	0 450		

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01480	Continued From page 10	01480		
01480 SS=F	144G.63 Subd. 3 Orientation to resident Staff providing assisted living services must be oriented specifically to each individual resident and the services to be provided. This orientation may be provided in person, orally, in writing, or electronically. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure staff providing assisted living services were oriented specifically to each individual resident and the services to be provided to each resident for two of two employees unlicensed personnel (ULP)-A and unlicensed personnel (ULP)-B including one resident reviewed (R1) This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1 admitted to the facility on January 16, 2026. R1's medical record indicated he fell and was transported to the hospital early on January 17, 2026. ULP-A ULP-A was hired March 25, 2024, to provide	01480		

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01480	Continued From page 11 direct are services to the licensee's residents. ULP-A's record lacked documentation of orientation to R1's services to be provided. ULP-B ULP-B was hired October 25, 2022, to provide direct are services to the licensee's residents. ULP-B's record lacked documentation of orientation to R1's services to be provided. During an interview on March 25, 2026, at 11:33 a.m., unlicensed personnel (ULP)-A stated there was a service for orientation to be completed in the computer. ULP-A stated the evening shift reported there was a new resident but did not report R1's diagnosis or anything else. During an interview on March 24, 2026, at 2:24 p.m., unlicensed personnel (ULP)-B stated there was a service for orientation to be completed in the computer. ULP-B stated there was no shift-to-shift report or anyone who told him about R1. During an interview on March 30, 2026, at 2:15 p.m., Executive Director (ED)-E stated staff were supposed to sign off on "orientation to the specific needs of the resident" task when they first start their shift. ED-E stated the task was available to be signed off the entire shift. ED-E also stated you would need to be assigned to a resident to see a task; therefore, a staff member may answer a call light and assist a resident prior to being orientated to their specific needs. The licensee-provided policy titled "Staff Orientation to Individual Resident" undated, indicated staff providing services will be oriented	01480		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34662	A. BUILDING: _____ B. WING _____	C 03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVENWOOD OF MINNETONKA	17710 OLD EXCELSIOR BOULEVARD 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
01480	Continued From page 12 specifically to each individual resident and the services to be provided. This orientation may be provided in person, orally, in writing, or electronically. TIME PERIOD FOR CORRECTION: Seven (7) days	01480		