Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Project: HL201074421M
Compliance Project: HL201075387C

Date Concluded: July 24, 2026

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: Lena Gangestad, 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 he was found on fire in the bathroom.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although the resident passed away, the resident did not have any history of suicidal ideation and was not a smoker before the incident.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family member. The investigation included review of resident's records, facility's policies and procedures, and incident reports. The investigation included an onsite visit, observations, and interactions between residents and facility staff.

The resident resided in an assisted living facility. The resident's diagnoses laryngeal cancer, status post tracheoesophageal puncture (TEP) and adjuvant radiation therapy. The resident's service plan included assist by cueing or standby assist.

The resident's progress notes indicated caregivers heard the fire alarm go off at approximately 12:30 a.m., ran into the hallway, witnessed smoke, and followed it to the resident's unit from which it came. The caregivers opened the door to the unit but did not see the resident in the bedroom, so they ran into the bathroom where smoke was coming from, and found the resident on fire, sitting against the shower wall. One caregiver ran to extinguish the fire while another called 911. The resident was pronounced deceased when the police arrived.

The resident's assessment from two months prior indicated the resident was oriented to person, place, and time. The same document indicated he was able to understand and follow instructions with no identified risk for self-abuse. The resident has history of throat cancer and cannot speak clearly unless holding hole in throat area.

The medication administration record indicated the staff administrated medication to the resident around 9:00 p.m. the prior evening but did not have any other scheduled cares after that.

The progress notes indicated that just day before the incident, the resident was in good spirits and agreed to have another provider come to the facility to see him. The resident returned from his doctor's appointment on the same day with a family member and stated they discussed tube feeding option because he could not eat. He was open to the idea and looking forward to seeing his family the next day for a holiday.

The police report indicated two lighters were found on the bed.

During an interview, a family member stated that the resident used to be a smoker and stopped smoking cigarettes when he had his laryngectomy. However, he recently told her that he smoked drugs through his laryngectomy by inhaling them through the stoma (opening). She said he never smoked in her presence, and she did not find out until recently, so she did not notify the facility. She had no concerns about the care provided to him and stated that the staff had been kind to him. She said he had a strong will to live and wanted to live.

During an interview, a staff member stated that he had worked with the resident for about a year and confirmed that the resident did not smoke due to his history of laryngectomy. The resident routinely went out into the community and returned without incident. On the day of the fire, the resident changed into clean clothes, went grocery shopping, and a staff member him carry the groceries upstairs.

During an interview, a manager stated that around midnight, caregivers called her and notified her of the fire involving the resident. The manager stated when the police arrived it was

decided to not evacuate everyone as it was a small and contained fire. The manager stated the resident had a history of smoking but had quit when he moved into the facility a year prior. There is no kitchen in his room, and no one had complained about him smoking. The resident had no history of suicidal ideation. The manager had met with him the day before and spoke of future plans, including a procedure scheduled two days later. The resident had been screened for depression, and when asked about suicidal thoughts, he denied having any. The manager stated the facility was unclear how the fire started although the police found two lighters on the bed, not in the bathroom with him.

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. The resident was deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility reported the case to the Minnesota Adult Abuse Reporting Center. They also educated the staff about the warning signs of suicide and provided safe smoking guidelines to all residents who smoked.

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 07/09/2024

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 9, 2024, the Minnesota Department of Health initiated an investigation of complaints #HL201074421M/HL201075387C, and #HL201075387C . No correction orders are issued.	0 000		