

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** HL294082084M  
**Compliance #:** HL294083590C

**Date Concluded:** July 30, 2025

## **Name, Address, and County of Licensee**

### **Investigated:**

Mendota Heights WP LLC  
745 South Plaza Drive  
Mendota Heights, MN 55120  
Dakota County

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

**Evaluator's Name:** James Larson, 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 they failed to administer a pain medication as scheduled. The resident did not receive the medication as prescribed for a period exceeding three days.

### **Investigative Findings and Conclusion:**

The Minnesota Department of Health determined neglect was not substantiated. Although a medication administration error occurred, the error was an isolated incident. The resident was monitored and treated according to the resident's individual assessed needs. There was not a preponderance of evidence to support that the actions of the facility staff met the definition of neglect.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, unlicensed staff as well as a member of the resident's family. The investigation included review of the resident's medical records, incident reports, employee training records,

policies and procedures were also reviewed. The investigation included an onsite visit where the investigator toured the facility and observed staff completing a medication count and well as providing care and services to resident.

The resident resided in an assisted living memory care unit. The resident's diagnoses included Alzheimer's Disease, kidney failure, as well as expressive aphasia (the loss of ability to speak or understand speech). The resident's service plan included assistance with medication administration, laundry, housekeeping, meal reminders, safety checks and behavior monitoring. The resident's assessment indicated the resident is deemed not able to safely self-administer medications or make his needs clearly known at times.

A review of complaint documents indicated that over a holiday weekend the resident did not receive a time sensitive scheduled medication. The resident was scheduled to have a transdermal (on the skin) pain medication patch placed every seventy-two hours.

The resident's medical record indicated that on a Friday evening, which was also the beginning a holiday weekend, an unlicensed staff member tasked with replacing the medicated patch documented that the medication was unavailable. This indicated that the replacement supply of available patches was zero. The nurse responsible for tracking and resupply of medication was not notified of the issue until the following Tuesday morning when they returned to the facility. It was also noted that facility staff failed to notify the available twenty-four hour on call nursing staff for direction and did not report that the medication was not available.

During an interview, the nurse stated that all team members who administer medications to residents at the facility were specifically trained in facility process and procedures involving medication services. She stated that after a staff member had indicated on the resident's medication administration record (MAR) that the medication was unavailable as scheduled, a failure to follow through with a notification to the nurse staff was identified. The nurse stated that once she returned to work after a holiday weekend, she was notified about the discrepancy and missed doses. She took steps to correct the issue including contacting the hospice provider who ordered a resupply of the medication. She also noted that the staff were continuing to monitor the resident throughout the weekend and were able to offer additional pain medication as needed.

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, attempted but unable to participate.

**Family/Responsible Party interviewed:** Yes

**Alleged Perpetrator interviewed:** Not Applicable

**Action taken by facility:**

The facility conducted an internal investigation, and the unlicensed personnel involved were provided reeducation and review by the facility nursing staff, along with letters of discipline.

**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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>29408</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/25/2025</b>
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NAME OF PROVIDER OR SUPPLIER  <b>MENDOTA HEIGHTS WP LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>745 SOUTH PLAZA DRIVE</b> <b>MENDOTA HEIGHTS, MN 55120</b>
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(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	<p><b>Initial Comments</b></p> <p>On June 25, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL294083589C/#HL294082083M. No correction orders are issued.</p> <p>On June 25, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL294083590C/#HL294082084M. No correction orders are issued.</p>	0 000		

Minnesota Department of Health  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_