STATE LICENSING COMPLIANCE REPORT

Report #: HL294082490C

Date Concluded: May 8, 2025

Name, Address, and County of Facility Investigated:
Mendota Heights WP LLC LC
745 South Plaza Dr
Mendota Heights, MN 55120
Dakota County

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

Evaluator's Name:
Julie Serbus
Special Investigator, Registered Nurse

The Minnesota Department of Health conducted a complaint investigation to determine compliance with state laws and rules governing the provision of care under Minnesota Statutes, Chapter 144G. The purpose of this complaint investigation was to review if facility policies and practices comply with applicable laws and rules. No maltreatment under Minnesota Statutes, Chapter 626 was alleged.

To view a copy of the correction orders, if any, please visit:
https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

Or call 651-201-4201 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached state form.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29408	A. BUILDING: _____ B. WING _____	C 04/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MENDOTA HEIGHTS WP LLC	745 SOUTH PLAZA DRIVE MENDOTA HEIGHTS, MN 55120

(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 ******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: #HL294082503C/#HL294081561M #HL294082490C On April 14, 2025, 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 36 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL294082503C/#HL294081561M, tag identification 2360 and 2310.	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.	
02310 SS=D	144G.91 Subd. 4 (a) Appropriate care and services	02310		

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02310	Continued From page 1 (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on interview, and document review, the licensee failed to ensure care and services were provided according to a suitable and up to date assessment, service plan, and individualized abuse prevention plan (IAPP) for 2 of 2 (R1 and R2) residents reviewed. 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). t The findings include: R1 R1 admitted to the facility February 18, 2019. R1's diagnoses included organic brain syndrome, personality and behavioral disorder. Review of R1's service plan dated January 30, 2025, identified R1's level of care as memory care (MC). R1's service plan did not identify or have interventions in place in a behavioral plan related to R1's prior display of sexual behaviors. R1's service plan did not address or have interventions in place concerning R1's past	02310		

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02310	Continued From page 2 history of smoking when R1 would go out to patio area and ask other residents who smoke for cigarettes and look for cigarette butts so smoke. R1's IAPP dated November 18, 2024, indicated R1 did not pose a risk of inappropriate sexual behaviors towards others and did not pose a smoking behavior. The document further summarized the resident does not appear to have any areas of vulnerability requiring intervention at this time and does not appear to pose a threat to other vulnerable adults. Review of R1's assessment dated December 18, 2024, indicated the resident did have a diagnosis of cognitive impairment/dementia. The assessment indicated the resident had a previous history of smoking but did not smoke. R1 was alert, responsive, forgetful, confused, and a poor decision-maker. R1 was oriented to person and place. R1 is at risk for elopement with every 2 hour safety checks and continuous redirection as needed by staff at the facility. Review of R1's progress notes dated December 6, 2023, at 12:04 p.m., indicated R1 displaying sexual interaction with a male resident. Progress notes indicated R1's family member was notified of the incident. Review of R1's progress notes dated March 24, 2025, at 3:40 p.m., indicated on March 22, 2025, and into the early morning hours of March 23, 2025, R1 was discovered in bed with a male resident. R1 was found to have hickeys on her neck indicating some kissing or contact had occurred. During an interview on April 14, 2025, at 12:47 p.m., unlicensed caregiver (ULP)-F stated R1	02310		

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02310	Continued From page 3 likes to show attention to male residents. During an interview on April 14, 2025, at 2:35 p.m., registered nurse (RN)-A stated they are aware R1 "had had many boyfriends here" and can be "flirtatious." During an interview on April 17, 2025, at 10:00 a.m., family member (FM)-C stated the most recent incident [referring to March 22, 2025] where R1 was in bed with another resident is not something new and not the first time this has happened. FM-C stated R1 had demonstrated sexual tendencies prior. Also, FM-C stated she has received calls from the facility in the past regarding R1 asking other residents in the facility who smoke for cigarettes. R2 R2's diagnoses included Parkinson's disease, depression, insomnia, restless legs syndrome, and generalized anxiety. R2's service plan dated February 17, 2025, indicated R2 level of care as assisted living resident (AL). R2's service plan did not include information regarding R2's ability to enter and exit the facility independently. R1's service plan did not indicate the resident having a code to exit and enter the facility independently and how to keep other vulnerable adults (VA) safe. The service plan failed to identify use of alcohol and interventions to keep R2 safe along with other VAs in the facility. R2's IAPP dated October 2, 2024, indicated R2 was vulnerable to alcohol use. The same document included interventions of frequent reassurance checks as able, keep other	02310		

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02310	Continued From page 4 vulnerable adults safe, and fill out behavior report and contact nursing if posing a risk to others while drinking alcohol. R2's uniform assessment dated January 13, 2025, indicated R2 was oriented to person, place, time, and situation. R2's assessment did not indicate R2 used alcohol and was at risk. The assessment indicated R2 did not have a diagnosis of cognitive impairment/dementia. The assessment indicated R2 does not have a history of elopement, does not wander aimlessly and is not a risk for elopement. Yet, R2's assessment indicated the resident would not be given the code to exit the building, that the facility is a locked building and staff will assist with code to exit as needed. R2's progress notes dated February 7, 2025, at 3:51 p.m., indicated R2 smelled of alcohol and when asked, R2 stated he did have sips of alcohol. R2 progress note dated March 24, 2025, at 5:06 p.m., indicated R2 had been drinking alcohol and was giving to another resident. During an interview on April 14, 2025, at 2:10 p.m., R2 stated he did have a code to exit and enter the facility as he enjoys going out for walks and can leave the facility whenever he chooses. R2 also stated he does drink alcohol. During an interview, on April 14, 2025, at 2:35 p.m., RN-A stated residents are assessed to keep them safe as the facility admits a wide variety of residents. RN-A stated the assessment indicates if a resident is able to safely be given a code to exit the facility. RN-A stated R2 has the right to drink alcohol and does drink.	02310		

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02310	Continued From page 5 During a second interview, on April 25, 2025, at 12:57 p.m., RN-A stated the assessment should have identified alcohol use. RN-A stated if staff notice resident stumbling or falling the staff can take the alcohol from him and notify nursing. RN-A stated medications can also be held if the resident is drinking. RN-A also stated she did not know why the assessment completed by nursing failed to document he was given a code to exit as the resident does have the code. During an interview, on April 24,2025, at 9:36 a.m., management (Mgt)-G stated R2 has a code to go in and out of locked patio area and leave the facility through the front door as he wishes. Mgt-G stated R2's assessment would indicate that he has the code. Mgt-G stated staff are aware who is an AL [assisted living] resident vs who is a MC [memory care] resident. The licensee policy titled 6.01 Assessment, Reviews & Monitoring, dated April 1, 2024, indicated a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moved in. The initial nursing assessment or reassessment must include all the elements of the uniform assessment tool as required, conducted in person, be in writing, dated, and signed by the registered nurse who conducted the assessment. Based on the RN's assessment of the resident's needs and vulnerabilities, the RN will develop a service plan that addresses the residents needs and included interventions necessary to reduce the client's risk of maltreatment or to reduce the risk that the client	02310		

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02310	Continued From page 6 may pose to other vulnerable adults. The licensee Uniform Disclosure of Assisted Living Services & Amenities (UDALSA), dated January 1, 2025, indicated the facility was an Assisted Living Facility with Dementia Care License. Section:1 Dementia Care indicate services available include secured unit or building for wandering or exit-seeking behavior. TIME PERIOD FOR CORRECTION: Seven (7) days.	02310		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure two of two residents reviewed (R1 and R2) were free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		