Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL294086883M
Compliance #: HL294086343C

Date Concluded: March 30, 2026

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: Willette Shafer, 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 resident-1, resident-2, and resident-3 when the facility failed to supervise the residents and resident-3 sexually assaulted resident-1 and resident-2.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Resident-3 exhibited no prior inappropriate sexual behaviors before the incident and the incidents occurred on the same day. Once the incidents of resident-3 suspected sexually touching of resident-1 and resident-2 were discovered, the facility implemented several interventions including moving resident-3's apartment closer to the nurse's station and away from resident-1 and resident-2's apartments. The facility locked resident-2's apartment door when she was in her apartment, and increased observations for all three residents. Behavioral interventions were added to resident-3's care plan including monitoring and reporting alcohol consumption and inappropriate sexual behaviors. The facility consulted with law enforcement and the

ombudsman. The facility continues to work with resident-3's care team to find a more appropriate placement.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family members. The investigation included review of the resident's records, facility internal investigation, facility incident reports, personnel files, staff schedules, law enforcement report, related facility policy and procedures. Also, the investigator toured the facility and observed staff providing resident care and supervision including safety checks.

Resident-1 resided in an assisted living memory care unit. Resident-1's service plan included assistance with medication management, bathing, grooming, dressing, alcohol use monitoring, smoking assistance, and safety checks every two hours.

Resident-2 resided in an assisted living memory care unit. Resident-2's service plan included assistance with medication management, bathing, dressing, redirection, transfers, behavioral monitoring, and safety checks every two hours.

Resident-3 resided in an assisted living memory care unit but did not receive memory care services and he was able to leave the facility independently in his wheelchair. Resident-3's service plan included safety checks every two hours, behavioral interventions including monitoring alcohol consumption, transferring with a full body lift to his wheelchair, meals, bathing, grooming, and medication management.

The internal investigation indicated resident-1 was observed in resident-3's apartment. Both residents were lying on resident-3's bed. Resident-1 was fully clothed lying on top of the covers and resident-3 had a shirt and brief on. No sexual activity was observed by staff, but resident-1 said resident-3 touched her vaginal area on top of her pants. Resident-1 was sent to the hospital for an examination, and law enforcement was called.

Resident-2's progress notes indicated she was sitting in her wheelchair in resident-3's apartment with only a brief and her shirt on, with a coat draped over her lap, and her pants in her hand. She had a small cup of alcohol mixed with soda. Facility staff never observed any sexual behaviors including touching, and resident-2 denied resident-3 touched her, but she was still sent to the hospital for examination. The hospital reported a sexual assault examination was not conducted as there was no evidence that an assault occurred. Resident-2 returned to the facility. No further concerns were documented after resident-2 returned.

Resident-3's progress notes indicated resident-1 was found in resident-3's bed lying on top of the covers with her shirt and brief on. While staff were assessing and talking with resident-1, staff observed resident-2 in his room sitting in her wheelchair holding her pants in her hand (shirt and brief on) with a jacket draped over her lap. The facility called law enforcement and resident-3 was arrested, brought to the police station and transferred to the hospital.

Resident-3 returned to the facility a few days later. Resident-3's apartment was moved closer to the nurse's station and away from resident-1 and resident-2 while trying to find a more appropriate placement.

Resident-3's care plan was updated after the incidents for behavioral interventions to include monitoring and reporting alcohol consumption and inappropriate sexual behaviors.

During an interview, a member of management said she was unaware of any sexually inappropriate behaviors by resident-3 before this incident. Although resident-3 was diagnosed with dementia he was able to leave the facility independently. Resident-3 only exhibited inappropriate behaviors when he drank alcohol. The facility tried to encourage resident-3 and other residents not to drink alcohol, but she said the ombudsman told the facility the residents had the right to drink alcohol. After the incident the police were called, and resident-3 was brought to jail. Resident-1 and resident-2 were sent to the hospital for evaluation. When resident-3 returned, facility staff were educated on more frequent observations. They also moved resident-3's apartment closer to the nurse's station and away from resident-1 and resident-2. All three residents were on two-hour safety checks and encouraged to attend activities in a central location where staff could easily observe them.

During an interview, the nurse said the incident was the first time resident-3 exhibited sexually inappropriate behaviors. After the incident, resident-3 only displayed sexually inappropriate behaviors when he drank alcohol. She said they tried to limit his alcohol intake, including keeping his alcohol in the nurse's station but the ombudsman said he had a right to keep his alcohol in his apartment and drink when he wanted. Although resident-3 was diagnosed with dementia, he did not have a guardian, and he was able to leave the facility independently. The facility was trying to find a more appropriate setting for him as he was mostly independent and would benefit from a setting with peers at the same functional level. She said several interventions were implemented after the incident including relocating resident-3, locking resident-2's door, educating staff on the incident, more frequent observations, and encouraging activities.

During an interview, the unlicensed personnel said resident-3 was polite when he was not drinking alcohol. Staff received education on resident-3's behaviors and interventions. Directive to staff was when resident-3 was observed drinking, staff are required to complete a behavior note and provide more frequent safety checks. The unlicensed personnel said he never observed sexually inappropriate behaviors by resident-3 before this incident. He said he observed resident-1 lying on his bed the day of the incident. He said they were lying close to each other, but he never observed any sexual touching. Resident-2 and resdeint-3 still tried to spend time together but there have been no further sexually inappropriate behaviors.

During an interview, resident-2's family member said the facility called her and reported resident-2 was found in resident-3's apartment with her pants off. The facility sent resident-2 to the hospital for evaluation. She said resident-2 and resident-3 often sat together in common

areas and during meals. She was not aware of any other time resident-2 was in resident-3's apartment but they continued to sit in common areas together. The facility said they moved resident-3 away from resident-2 and they encouraged them to spend time with other people. She said before the incident they were both friendly towards each other but nothing sexual.

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: Resident-1- No, due to cognition. Resident-2- No, due to cognition. Resident-3- Declined.
Family/Responsible Party interviewed: Resident-1's family never responded to interview request. Resident-2's family- Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility contacted the police, sent the other residents to the hospital for evaluation, completed an internal investigation, and moved resident-3's room closer to the nurse's station and away from resident-1 and resident-2.

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
	29408	A. BUILDING: _____ B. WING _____	C 02/11/2026

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 On February 11, 2026, the Minnesota Department of Health initiated an investigation of complaint HL294086343C/HL294086883M and HL294081580C/HL294088582M. No correction orders are issued.	0 000		