



Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL294087764M
Compliance #: HL294084572C

Date Concluded: December 21, 2023

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: Deb Schillinger, 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 the facility administered incorrect medications to the resident.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined neglect was not substantiated. Although the resident was given the wrong medications, the facility took appropriate action when the error was identified. After monitoring in the hospital, the resident returned to her healthcare baseline.

The error was an isolated incident, and no harm occurred to the resident and returned to their baseline health condition.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed caregivers. The investigator contacted the resident's family member. The investigation included review of resident records, incident reports, internal investigations, employee records and facility policies and procedures. Also, the investigator observed medication administration procedures.

The resident resided in an assisted living memory care unit. The resident's diagnoses included Parkinson's disease and vascular dementia. The resident's service plan included assistance with medication management and administration.

The facility incident report indicated the unlicensed caregivers administered the resident incorrect medications; the unlicensed caregiver immediately reported the medication error to the facility nurse. The resident was immediately transferred to the hospital where she was monitored and returned to facility. The resident's medical records indicated she remained at her baseline health status.

During interviews, several unlicensed caregivers stated the proper procedure for medication administration was to follow the six rights of medication administration which included identifying the resident before administering medication.

During an interview, a registered nurse (RN) stated all employees are trained on proper medication administration. The RN stated the unlicensed caregivers immediately notified the nurse when the medication error was identified, the unlicensed caregiver was removed from medication cart duties and re-educated on the medication administration policy.

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: Not able, cognitively impaired.

Family/Responsible Party interviewed: Yes.

Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:

The facility retrained the unlicensed caregiver on medication administration.

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: 29408	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/25/2023
NAME OF PROVIDER OR SUPPLIER MENDOTA HEIGHTS WP LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 September 27, 2023, the Minnesota Department of Health initiated an investigation of complaint #HL294084572C/#HL294087764M No correction orders are issued. On October 25, 2023, the Minnesota Department of Health initiated an investigation of complaint #HL294086398C/#HL294088925M and HL294086397C. No correction orders are issued.	0 000			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE