Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL294088582M
Compliance #: HL294081580C

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 the resident when the facility failed to provide medical care to maintain the resident's weight, mental health symptoms, and wounds.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The facility monitored and assessed the resident's mental and physical health needs appropriately. The facility sent the resident to the hospital multiple times due to mental and physical health concerns. An outside provider managed the resident's wounds including dressing changes and some wounds had improvement. The facility monitored the resident's intake and his weight remained stable until the end of his life. The facility made several referrals for outside services and petitioned for a guardian.

The investigator conducted interviews with facility nursing staff. The investigator contacted the resident's family member and case manager. The investigation included review of the resident's

medical record, death record, incident reports, behavioral health record, staff schedules, and related facility policy and procedures. Also, the investigator toured the facility and observed facility staff providing care to the residents including grooming, toileting, medication management, and meal services.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia, bipolar disorder, heart failure, strokes, peripheral vascular disease (poor blood flow to extremities), chronic obstructive pulmonary disease (progressive lung disease that restricts airflow), cellulitis, and anxiety. The resident's service plan included assistance with toileting, grooming, bathing, medication management, behavioral management, and safety checks.

The resident's progress notes indicated the resident's primary care provider along with outside providers monitored the resident's edema closely and adjusted his medications for fluid retention regularly. The resident's weights were also closely monitored.

The resident's vital signs and weight log indicated the resident had gained eight pounds over the last seven months. The resident's weight only declined at the end of his life while on hospice.

The resident's food intake log indicated the resident ate 100% of his food on numerous dates.

The resident's progress noted indicated he was sent to the hospital for various reasons throughout his admission including his mental health. The resident exhibited psychotic symptoms including many delusions. During his hospital admission, the resident was physically aggressive towards other patients. His medications were adjusted while at the hospital and monitored by behavioral health at the facility. The facility communicated with the hospital social worker about setting up guardianship for the resident because the resident was too ill to manage his care and make his own decisions. The facility completed the petition for guardianship and submitted forms to the county.

The resident's progress notes indicated the facility updated the resident's primary care provider regularly and received several new orders to ensure the resident's mental and physical health needs were met. The resident had recent orders and recommendations for physical therapy, occupational therapy, medication review due to recent falls, nephrology, and vascular. A referral for hospice was recommended as the resident had several falls, recent hospital visits, infections, medication adjustments, and overall mental and physical health decline.

The resident's progress notes indicated his wound was managed by an outside wound care provider and one wound healed.

The resident's last nursing assessment dated one month before his death indicated the resident had a significant change in condition and was enrolled in hospice.

During an interview, the family member said the facility did not give her much information about the resident's health, diagnoses, or care. She said the resident was independent, did not have a guardian, and did not want the facility to give the family information about him because he was paranoid. She said the resident had schizophrenia, bipolar disorder and a long history of delusions. He frequently declined assistance and was not always cooperative with his care plan. He had many delusions including his family being in prison. She was concerned the facility was not managing his mental health, including mental health medications. The family member was concerned he was losing weight, and his wounds were not being cared for. She was concerned he was losing weight because he did not have teeth, and he could not see and needed glasses. When she visited in the past, the resident appeared disheveled. He often refused care because he believed the facility was trying to kill him. She said she used to bring the resident cigarettes, but she was unable to visit recently due to personal reasons.

During an interview, the nurse said the resident had a long history of mental health issues. The facility sent him to the hospital several times due to his mental health concerns. His medications were managed by a mental health practitioner and the hospital. He had multiple paranoid delusions. He was on several medications for his mental health symptoms which were monitored and adjusted regularly. An outside wound care company managed his wounds, and he was seen at the hospital for his wounds, edema, and vascular issues. His medications for his edema were managed closely and adjusted regularly. His intake was monitored, and the resident's diet was adjusted based on his preferences and medical needs. The resident was admitted to hospice several months before his death. He had glasses but refused to wear them. He was resistant to staff assistance with care and behavioral interventions were implemented to support the resident. The facility consulted with the family, but the resident was reluctant to give the family information about his health.

During an interview the resident's case manager denied she had concerns with the care the resident received at the facility. She said she spoke with the facility a few times regarding the facility's request to find a guardian for the resident.

The resident's death record indicated his cause of death was related to dementia.

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, deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility provided appropriate assessment, evaluation, and medical care to the resident timely.

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		