Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL366516524M
Compliance #: HL366519739C

Date Concluded: February 6, 2025

Name, Address, and County of Licensee Investigated:

Lexington Pointe Senior Living
3385 Discovery Road
Eagan, MN 55121
Dakota County

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

Evaluator's Name: Brooke Anderson, 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 alleged perpetrator (AP), a facility staff. neglected the resident when the resident was given the wrong medications resulting in hospitalization.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although a medication error occurred, the error was an isolated incident. Upon discovery of the error, staff notified the facility nurses, emergency medical services, and the resident was sent to the hospital for evaluation. The resident returned to their baseline health condition.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement. The investigation included review of the resident record, hospital records, facility internal investigation, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed interactions between staff and residents.

The resident resided in an assisted living memory care unit. The resident's diagnoses included Alzheimer's Disease and heart disease. The resident's service plan included assistance with medication administration. The resident's assessment indicated the resident was orientated to self with forgetfulness and confusion.

An incident report indicated a facility staff member set up medications and requested the AP administer them to the resident. The AP administered the resident the preset-up medications; however, the preset-up medications were another resident's medications.

A progress note indicated the AP reported to a facility nurse that she administered the resident the wrong medications and requested the nurses assess the resident. When facility nurses arrived, the resident was alert, but had low respirations. Emergency medical services and family was notified. The resident was sent to the hospital for treatment.

Hospital Records indicated the resident was "inadvertently" administered a different resident's medications. While at the hospital the resident did not receive medical intervention and was discharged back to the facility with a family member when the resident was more alert.

During an interview, the AP stated a coworker asked her to administer medications to a resident. The AP stated there was miscommunication and she administered the medication to the wrong resident. The incident was a mistake. After the incident, the facility provided education to the AP and no additional medication errors have occurred since the incident.

During an interview, a facility nurse stated the AP called and requested the resident be assessed after she administered the wrong medications. A facility nurse stated the resident was sent to the hospital and returned that evening and later returned back to her baseline health condition. After the incident, the AP was re-educated and there have been no additional concerns with care provided by the AP.

During an interview, a family member stated she was notified of the incident, the resident was evaluated in the emergency room and discharged back to the facility. A family member stated the resident returned to her baseline health condition after approximately one week.

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: Yes.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility investigated the incident and completed education to all facility staff including staff involved in the incident.

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
	36651	A. BUILDING: _____ B. WING _____	C 01/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEXINGTON POINTE SENIOR LIVING	3385 DISCOVERY ROAD EAGAN, MN 55121

(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 January 13, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL366519739C/#HL366516524M. No correction orders are issued.	0 000		