DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL294081402M
Compliance #: HL294088961C

Date Concluded: June 18, 2024

Name, Address, and County of Licensee Investigated:
Mendota Heights White Pine
745 South Plaza Drive
Mendota Heights, MN 55120
Dakota County

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

Evaluator's Name: Brandon Martfeld, RN BSN
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 supervision to the resident. The resident was able to learn the door codes of the secured memory care unit and leave the facility unsupervised. In addition, an alleged perpetrator (AP), an unknown facility staff member neglected the resident when the AP supplied alcohol for the resident.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. When admitted to the facility, the resident required a secured memory care unit because of cognitive impairment. The resident was able to learn the door code at the facility and left the facility unsupervised. The facility notified the resident's provider, and a cognitive assessment was completed with the resident. The assessment indicated the resident no longer had cognitive impairment and could leave the facility unsupervised. In addition, there was no evidence that a facility staff member supplied the resident with alcohol.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's mental health care coordinator and guardian. The investigation included review of the resident records, facility incident reports, staff schedules, and related facility policy and procedures. Also, the investigator observed staff and resident interactions.

The resident resided in an assisted living memory care unit. The resident's diagnoses included alcohol dependence and mild cognitive impairment. The resident's service plan included every two-hour safety check and medication administration. The resident was independent with activities of daily living and needed placement in a secured facility. The resident was not safe to leave the facility unsupervised.

The resident's medical record indicated the resident was able to memorize the codes to the facility's locked doors. The resident would walk to a pharmacy or a liquor store located across the street from the facility.

During an interview, the mental health care coordinator stated when the resident admitted to the facility, the resident scored low on a cognitive test. The test indicated the resident was not safe to leave the facility unsupervised and needed a secured memory care unit. The resident had a couple incidences of leaving the facility unsupervised. The mental health care coordinator stated once it was discovered the resident was leaving the facility unsupervised a new cognitive test was completed. The cognitive test indicated the resident's cognition improved from when she was first admitted to the facility. The resident was able to leave the facility unsupervised.

During an interview, leadership stated when resident admitted to the facility, the resident had memory impairment and was not provided the code to the secured doors. The resident learned the locked door codes from another resident or by watching facility staff. The resident would sneak out of the facility. Leadership stated if staff saw the resident attempt to leave, staff would intervene and redirect the resident back into the facility. Leadership stated the door codes were changed and an order from the resident's provider for an occupational therapy assessment was requested and the resident was reassessed. After occupational therapy reassessed the resident, it was determined the resident's cognition improved and the resident was safe to leave the facility unsupervised.

During an interview, the resident stated she had a traumatic brain injury. The resident stated she did not recall how or when, but she was able to get the code to the secured doors. The resident left the facility to go to the pharmacy or to a liquor store. The resident stated the facility did an assessment and she can leave the facility unsupervised. The resident stated she signs out in a book and tells staff when she leaves the facility. The resident denied any staff member giving her alcohol.

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: Not Applicable.

Action taken by facility:
Education was provided to the resident about safety when leaving the facility. A physician order was obtained for occupational therapy for a cognition assessment.

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 05/20/2024

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 May 20, 2024, the Minnesota Department of Health initiated an investigation of complaints #HL294082340M / HL294081405C #HL294081960M / HL294089742C #HL294081402M / HL294088961C No correction orders are issued.	0 000		