*Protecting, Maintaining and Improving the Health of All Minnesotans*

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** HL294081561M **Date Concluded:** May 8, 2025
**Compliance #:** HL294082503C

**Name, Address, and County of Licensee Investigated:**
Mendota Heights WP LLC LC
745 South Plaza Dr
Mendota Heights, MN 55120
Dakota County

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

**Evaluator's Name:** Julie Serbus, RN
Special Investigator

**Finding:** Substantiated, facility responsibility

**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, who was assessed as a memory care resident, and resident #2, assessed as an assisted living resident, when the facility did not provide supervision, and the two residents were found in bed together.

**Investigative Findings and Conclusion:** The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment.

- The facility neglected resident #1, who was designated as a memory care resident who could not safely leave the unit unsupervised, when it did not address her "boyfriend" relationship with other male residents in the past. While resident #1 may have these relationships, the facility did not take steps to ensure the relationship(s) did not result in abuse.

- The facility neglected resident #2, who was designated as an assisted living resident who could safely leave the unit unsupervised, when it did not provide him with supervision in a setting that included memory care residents.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted family members. The investigation included review of resident record(s), resident assessments, service plans, individual abuse prevention plan, facility internal investigation, staff schedules, and related facility policy and procedures. Also, the investigator made an onsite visit to the facility, spoke with resident #1 and resident #2 and observed the location of resident #1 and resident #2's rooms.

**The Facility**

The facility is licensed as an assisted living facility with dementia care with a secured dementia care unit (SDCU). An SDCU means a designated area or setting designed for individuals with dementia that is locked or secured to prevent a resident from exiting, or to limit a resident's ability to exit, the secured area or setting.

A review of the admission practices indicated the facility opted to place resident who require a secured dementia care unit along side resident who do not require secured unit within the same setting.

As such the facility designates individual residents either assisted living residents and others as "memory care" residents. The facility differentiates between residents who may come and go freely as "assisted living residents" and those who may not as "memory care" but provides living quarters within the same building for both.

A facility-provided policy regarding admissions indicated the assisted living director, in cooperation with the registered nurse, is responsible for admitting residents to the facility. The same document indicated the facility will not admit a resident unless it can provide supervision to meet the resident's mental, cognitive or behavioral condition.

**The Incident**

Resident #1's progress notes indicated during an overnight shift a caregiver found resident #1 and resident #2 together in resident #1's bed fully dressed except for resident #2 did not have a shirt on. Two hours later on the next set of rounds resident #1 and resident #2 were found again together on top of the bed but in resident's #2's room clothed. Resident #1's neck had bruise marks indicative of kissing on her neck. The same progress note indicated resident #2 stated they had not kissed saying resident #1 was like a "girlfriend" to him and that she "always" flirts with him and kisses him when they were outside.

The documentation did not indicate the facility staff member(s) took any action during the shift, although the staff member(s) were educated that residents to not allow residents in each other's beds.

The facility internal investigation of suspected maltreatment indicated both residents denied anything sexual happened.

During an interview, unlicensed caregiver #1 stated she was scheduled to work the overnight shift with her shift beginning at 10:30 p.m. Caregiver #1 stated the following:

- Between 11:00 PM and 11:20 PM started her every two-hour reassurance checks. Caregiver #1 went to resident #1's room and found resident #1 and resident #2 fully dressed and lying in bed together. Caregiver #1 did not separate the two as she was not sure of the relationship or facility policy on how to handle and left R1's room.
- Between 12:20 AM and 12:40 AM caregiver #1 stated she went to resident #2's room to offer medication and found resident #1 and resident #2 lying in bed together. Caregiver #1 stated resident #1 was fully dressed, and resident #2 was dressed but did not have a shirt on. Again, caregiver #1 stated she left resident #2's room and did not separate resident #1 and resident #2.
- 1:20 AM caregiver #1 stated resident #2 assisted resident #1 outside to the patio area. Caregiver #1 stated the residents where outside for about 20 minutes to smoke. Caregiver #1 stated she was assisting another resident located in the room across from resident #1 when she observed resident #2 pushing resident #1 back to her room and then resident #2 left and returned to his room.

During an interview, unlicensed caregiver #2 stated when she came in the next morning for her shift received report from caregiver #1 what had occurred during the overnight shift. Caregiver #2 stated she asked caregiver #1 if she reported this information to the on-call nurse as resident #1 was a memory care resident and resident #2 was an assisted living resident. Caregiver #1 stated she had not called to report the incident. Caregiver #2 stated at breakfast that morning she noticed resident #1 had red marks on her neck. Caregiver #2 asked another staff to look at resident #1's neck and determined the marks to be hickeys (bruise caused by sucking on an area).

**Resident #1**

Resident #1 's diagnoses included organic brain syndrome (a problem with the brain affecting the way a person thinks, remembers, and behaves), personality disorder, and behavioral disorder. Resident #1 's face sheet indicated resident #1 had lived at the facility for several years and was designated as memory care.

Resident #1 's service plan indicated assistance of one staff for dressing, grooming, toileting, transfer assist, medication administration, and every two-hour reassurance checks. The service plan indicated behavioral intervention for cognition and incidents of behavior use non-pharmacological or as needed pharmacological and complete a behavior analysis form.

This service plan did not indicate any behaviors of being sexual. The plan identified resident #1 was not a smoker and did not indicate resident #1 displays inappropriate sexual behaviors towards others.

Resident #1's assessment prior to this incident assess her for elopement risk which indicated she was cognitively impaired with poor decision-making skills due to organic brain disorder. The same indicated interventions included in a locked unit, every two-hour safety checks, and continuous redirection as needed by facility staff. The same assessment indicated she was alert and responsive, but forgetful, confused, had poor decision-making, and memory loss while alert and oriented to person and place but not time.

Resident #1 's individualized vulnerable adult abuse prevention plan indicated resident #1 interventions included to maintain reality-oriented and environments like clocks and calendars. Staff members were to notify nursing of any bruising. The same document indicated resident #2 did not demonstrate recognition of hazards in the environment and did not have the ability to leave the facility alone.

During an interview, family member #1 stated this is not the first time this has happened and basically this is not the first report of resident #1 found in bed with another resident. Family member #1 stated in the past have received calls from the facility regarding resident #1 asking other residents who smoke for a cigarette.

During an interview, a nurse stated resident #2 had been upset with her, so she had asked another nurse to speak with resident #2. The nurse stated she had directed the nurse who was to speak with resident #2 to remind him resident #1 is considered a memory care resident, and he is considered an assisted living resident and should not be in each other's rooms. The nurse stated they are aware resident #1 had "boyfriend" relationships in the past and could be "flirtatious."

Although both a family member and a facility nurse indicated resident #1 had relationships with other residents, a review of resident #1's medical record did not find documentation indicating the facility had addressed this issue nor given unlicensed caregivers direction on how to address with regard to resident #1.

In conclusion, the Minnesota Department of Health determined neglect was substantiated with regards to resident #1.

**Resident #2**

Resident #2's diagnoses included Parkinson's disease, depression, insomnia, and generalized anxiety. Resident #2's face sheet indicated he had lived at the facility for several months and was designated as assisted living.

Resident #2's service plan indicated the resident received medication administration, meals, weekly light housekeeping and laundry. This same document indicated resident was independent with all his activities of daily living (mobility, bathing dressing, toileting, transferring, and eating).

Resident #2's individualized abuse prevention plan indicated the resident was vulnerable as he was at "risk for alcohol abuse." The same document indicated resident did smoke and was allowed to smoke outside away from other nonsmoking residents. The same document also indicated the resident did not pose a potential risk to others with his smoking. Resident #2 was not at risk for inappropriate sexual behaviors towards others.

Resident #2's multiple assessments indicated resident #2 has been assessed for safely smoking without supervision and oriented to person place, time, and situation with no diagnosis of dementia or cognitive impairment. The assessment indicated the resident was not a risk for elopement but would not be given a code to exit the building and instead caregivers would assist with the code to exit as needed. The same documents indicated resident #2 was on every two-hour safety checks due to risk for elopement.

During an interview and contrary to his assessments resident #2 stated he did have the access code for the facility. Resident #2 stated he can the leave the facility when he wants and likes to go for walks. Resident #2 stated there are too many dementia residents for him to properly socialize and talk to.

Regarding the incident, resident #2's progress notes regarding the incident indicated resident #2 denied resident #1 being in his room but did state he was in her room talking. Resident #2 said he wheeled resident #1 into her room, sat, and talked with her. The same note indicated he responded "no" when asked if he kissed resident #1 but indicated she was being flirty and she kissed him.

About a week after the incident, resident #2's progress notes indicated he was drinking and giving alcohol to one of his fellow residents. Resident #2 was asked to not give alcohol to the other resident.

A review of the resident roster indicated the other resident was designated assisted living. However, the other resident's medical record indicated he was a memory care resident with high risk for elopement.

During an interview, a regional nurse stated residents in the facility are listed as MC [memory care] or AL [assisted living]. The regional nurse stated residents are not made aware of resident's level of care as to whether they are considered MC or AL to protect the residents and as to not violate HIPPA. Unlicensed caregivers carry electronic tablets which shows each resident's level of care. The regional nurse stated the facility nurse completes assessments to determine which residents are safe to have a code for the door.

The nurse stated assessments are completed by a nurse which is not always her but a nurse who works for the company and, if they have questions, they will ask the nurse who works at the facility. The nurse stated smoking, alcohol, and door code assessments are all addressed in the assessment. Regarding resident #2's assessment, she stated she did not know why his assessment did not indicate he at risk for alcohol use. The nurse stated that she was unsure if resident #2 was aware that resident #1s was a memory care level resident but he was aware now because she told him.

The facility had inconsistencies in its assessment and implementation of its care plan for resident #2. Meanwhile, the facility did not provide sufficient supervision of resident #2 in a setting of residents who the facility deemed memory care.

In conclusion, the Minnesota Department of Health determined neglect was substantiated with regards to resident #2.

**Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.**
"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

**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**: NA

**Action taken by facility:** The facility investigated the incident and updated resident #1 and resident #2's individualized abuse prevention plan to reflect risk of sexual behaviors.

**Action taken by the Minnesota Department of Health:** The responsible party will be notified of their right to appeal the maltreatment finding.

The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies. You may also call 651-201-4200 to receive a copy via mail or email

cc:
Office of Ombudsman for Long Term Care
Office of Ombudsman for Mental Health and Developmental Disabilities
Dakota County Attorney
Mendota Heights City Attorney
Mendota Heights Police Department

| 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 04/14/2025 |

| 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 |
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| 0 000 | Initial Comments<br><br>******ATTENTION******<br><br>ASSISTED LIVING PROVIDER CORRECTION ORDER<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation.<br><br>Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance.<br><br>INITIAL COMMENTS:<br><br>#HL294082503C/#HL294081561M<br>#HL294082490C<br><br>On April 14, 2025, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 36 residents receiving services under the provider's Assisted Living with Dementia Care license.<br><br>The following correction order is issued for #HL294082503C/#HL294081561M, tag identification 2360 and 2310. | 0 000 | Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction.<br><br>PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3. | |
| 02310 SS=D | 144G.91 Subd. 4 (a) Appropriate care and services | 02310 | | |

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| 02310 | Continued From page 1<br><br>(a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview, and document review, the licensee failed to ensure care and services were provided according to a suitable and up to date assessment, service plan, and individualized abuse prevention plan (IAPP) for 2 of 2 (R1 and R2) residents reviewed.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). t<br><br>The findings include:<br><br>R1<br>R1 admitted to the facility February 18, 2019.<br><br>R1's diagnoses included organic brain syndrome, personality and behavioral disorder.<br><br>Review of R1's service plan dated January 30, 2025, identified R1's level of care as memory care (MC). R1's service plan did not identify or have interventions in place in a behavioral plan related to R1's prior display of sexual behaviors. R1's service plan did not address or have interventions in place concerning R1's past | 02310 | | |

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| 02310 | Continued From page 2<br><br>history of smoking when R1 would go out to patio area and ask other residents who smoke for cigarettes and look for cigarette butts so smoke.<br><br>R1's IAPP dated November 18, 2024, indicated R1 did not pose a risk of inappropriate sexual behaviors towards others and did not pose a smoking behavior. The document further summarized the resident does not appear to have any areas of vulnerability requiring intervention at this time and does not appear to pose a threat to other vulnerable adults.<br><br>Review of R1's assessment dated December 18, 2024, indicated the resident did have a diagnosis of cognitive impairment/dementia. The assessment indicated the resident had a previous history of smoking but did not smoke. R1 was alert, responsive, forgetful, confused, and a poor decision-maker. R1 was oriented to person and place. R1 is at risk for elopement with every 2 hour safety checks and continuous redirection as needed by staff at the facility.<br><br>Review of R1's progress notes dated December 6, 2023, at 12:04 p.m., indicated R1 displaying sexual interaction with a male resident. Progress notes indicated R1's family member was notified of the incident.<br><br>Review of R1's progress notes dated March 24, 2025, at 3:40 p.m., indicated on March 22, 2025, and into the early morning hours of March 23, 2025, R1 was discovered in bed with a male resident. R1 was found to have hickeys on her neck indicating some kissing or contact had occurred.<br><br>During an interview on April 14, 2025, at 12:47 p.m., unlicensed caregiver (ULP)-F stated R1 | 02310 | | |

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| 02310 | Continued From page 3<br>likes to show attention to male residents.<br><br>During an interview on April 14, 2025, at 2:35 p.m., registered nurse (RN)-A stated they are aware R1 "had had many boyfriends here" and can be "flirtatious."<br><br>During an interview on April 17, 2025, at 10:00 a.m., family member (FM)-C stated the most recent incident [referring to March 22, 2025] where R1 was in bed with another resident is not something new and not the first time this has happened. FM-C stated R1 had demonstrated sexual tendencies prior. Also, FM-C stated she has received calls from the facility in the past regarding R1 asking other residents in the facility who smoke for cigarettes.<br><br>R2<br><br>R2's diagnoses included Parkinson's disease, depression, insomnia, restless legs syndrome, and generalized anxiety.<br><br>R2's service plan dated February 17, 2025, indicated R2 level of care as assisted living resident (AL). R2's service plan did not include information regarding R2's ability to enter and exit the facility independently. R1's service plan did not indicate the resident having a code to exit and enter the facility independently and how to keep other vulnerable adults (VA) safe. The service plan failed to identify use of alcohol and interventions to keep R2 safe along with other VAs in the facility.<br><br>R2's IAPP dated October 2, 2024, indicated R2 was vulnerable to alcohol use. The same document included interventions of frequent reassurance checks as able, keep other | 02310 | | |

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| 02310 | Continued From page 4<br><br>vulnerable adults safe, and fill out behavior report and contact nursing if posing a risk to others while drinking alcohol.<br><br>R2's uniform assessment dated January 13, 2025, indicated R2 was oriented to person, place, time, and situation. R2's assessment did not indicate R2 used alcohol and was at risk. The assessment indicated R2 did not have a diagnosis of cognitive impairment/dementia. The assessment indicated R2 does not have a history of elopement, does not wander aimlessly and is not a risk for elopement. Yet, R2's assessment indicated the resident would not be given the code to exit the building, that the facility is a locked building and staff will assist with code to exit as needed.<br><br>R2's progress notes dated February 7, 2025, at 3:51 p.m., indicated R2 smelled of alcohol and when asked, R2 stated he did have sips of alcohol.<br><br>R2 progress note dated March 24, 2025, at 5:06 p.m., indicated R2 had been drinking alcohol and was giving to another resident.<br><br>During an interview on April 14, 2025, at 2:10 p.m., R2 stated he did have a code to exit and enter the facility as he enjoys going out for walks and can leave the facility whenever he chooses. R2 also stated he does drink alcohol.<br><br>During an interview, on April 14, 2025, at 2:35 p.m., RN-A stated residents are assessed to keep them safe as the facility admits a wide variety of residents. RN-A stated the assessment indicates if a resident is able to safely be given a code to exit the facility. RN-A stated R2 has the right to drink alcohol and does drink. | 02310 | | |

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| 02310 | Continued From page 5<br><br>During a second interview, on April 25, 2025, at 12:57 p.m., RN-A stated the assessment should have identified alcohol use. RN-A stated if staff notice resident stumbling or falling the staff can take the alcohol from him and notify nursing. RN-A stated medications can also be held if the resident is drinking. RN-A also stated she did not know why the assessment completed by nursing failed to document he was given a code to exit as the resident does have the code.<br><br>During an interview, on April 24,2025, at 9:36 a.m., management (Mgt)-G stated R2 has a code to go in and out of locked patio area and leave the facility through the front door as he wishes. Mgt-G stated R2's assessment would indicate that he has the code. Mgt-G stated staff are aware who is an AL [assisted living] resident vs who is a MC [memory care] resident.<br><br>The licensee policy titled 6.01 Assessment, Reviews & Monitoring, dated April 1, 2024, indicated a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moved in. The initial nursing assessment or reassessment must include all the elements of the uniform assessment tool as required, conducted in person, be in writing, dated, and signed by the registered nurse who conducted the assessment. Based on the RN's assessment of the resident's needs and vulnerabilities, the RN will develop a service plan that addresses the residents needs and included interventions necessary to reduce the client's risk of maltreatment or to reduce the risk that the client | 02310 | | |

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| 02310 | Continued From page 6<br>may pose to other vulnerable adults.<br><br>The licensee Uniform Disclosure of Assisted Living Services & Amenities (UDALSA), dated January 1, 2025, indicated the facility was an Assisted Living Facility with Dementia Care License. Section:1 Dementia Care indicate services available include secured unit or building for wandering or exit-seeking behavior.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days. | 02310 | | |
| 02360 | 144G.91 Subd. 8 Freedom from maltreatment<br><br>Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act.<br><br>This MN Requirement is not met as evidenced by:<br>The facility failed to ensure two of two residents reviewed (R1 and R2) were free from maltreatment.<br><br>Findings include:<br><br>The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details. | 02360 | | |