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 #: HL294081960M
Compliance #: HL294089742C

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: Inconclusive

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 member, abused resident #1 and resident #2) when the AP slapped each resident on the face.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was inconclusive. There were conflicting reports of what occurred. A facility staff member reported the AP said she had "bitch slapped" resident #1 and "bop" resident #2 in the face if he became difficult during cares. The AP denied both allegations. There were no witnesses to the alleged incidents.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement and completed an interview with the AP. The investigation included review of resident #1 and resident #2's records, resident #1's hospital records, the facility internal investigation, facility incident reports, personnel files, staff schedules, law enforcement report, photos, a recorded

interview of resident #1, and related facility policy and procedures. Also, the investigator observed staff and resident interactions at the facility.

Resident #1 resided in an assisted living memory care unit. The resident's diagnoses included dementia and bipolar disorder. Resident #1's service plan indicated resident #1 required assistances from staff for all activities of daily living, was severely cognitively impaired, and answered simple yes and no questions. Resident #1 was at risk for abuse and staff had been trained on preventing and reporting abuse situations.

Resident #2 resided in an assisted living memory care unit. Resident #2's diagnoses included dementia. Resident #2's service plan included assistance with behavior interventions when refusing cares, such as involving family, reapproaching resident #2, offering to listen to music and as needed medications. Resident #2 was severely cognitively impaired with expressive aphasia (a partial loss of the ability to produce language.) Resident #2 was at risk for abuse and staff had been trained on preventing and reporting abuse situations.

Resident #1's records indicated the AP came out of resident #1's room and reported to a staff member that she had hit resident #1 during cares. Resident #1 was sent to the hospital for an evaluation.

Resident #1's hospital record indicated the resident had no pain and there were no signs of abuse. The hospital record indicated while at the emergency room, resident #1 could not remember why she was at the hospital.

During the facility's internal investigation of resident #1, the staff member reported the AP also stated she would "bop" resident #2 on the face if resident #2 was difficult with cares.

During investigation, an undated video recording by facility staff of resident #1 was provided. The video showed no evidence of an imprint of a slap mark on resident #1's face. During the recorded video resident #1 was asked if "she" hit you on your face, resident #1 shook her head no.

During the facility investigation, resident #2 could not remember if he was hit or not. Leadership stated the AP denied hitting the residents. Resident #1 and resident #2 did not have cameras in their rooms at the time of the incident.

During an interview unlicensed personnel stated the AP came out of resident #1's room and told the unlicensed personnel the AP had to "bitch slap" resident #1. The unlicensed personnel also stated the AP stated she also was aggressive with resident #2. The unlicensed personal went into resident #1's room and found a two-inch-by-two-inch red mark on resident #1's face. The unlicensed personnel stated resident #1 stated the AP had slapped resident #1's face.

During investigative interviews, multiple unlicensed staff members stated the AP did not talk about hitting or abusing residents. Multiple unlicensed staff members stated while working with the AP they never witnessed the AP hit or abuse the residents.

During an interview, leadership stated the incident with resident #1 was not reported to leadership immediately. During an interview with resident #1, the resident stated she was hit in the face and stomach. Resident #1 was assessed by a nurse and had no apparent injuries.

During an interview the AP stated she was the only person that tried to de-escalate resident #1's and resident #2's behaviors. The AP denied telling a co-worker she hit resident #1 and resident #2 when they were difficult during cares.

During investigative interviews, resident #1 and resident #2 both denied being hit by a staff member.

During an interview, law enforcement stated charges were dropped against the AP.

In conclusion, the Minnesota Department of Health determined abuse was inconclusive.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or did not occur.

Abuse: Minnesota Statutes section 626.5572, subdivision 2.
"Abuse" means:
(a) An act against a vulnerable adult that constitutes a violation of an attempt to violate, or aiding and abetting a violation of:
(1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224;
(2) the use of drugs to injure or facilitate crime as defined in section 609.235;
(3) the solicitation, inducement, and promotion of prostitution as defined in section 609.322; and
(4) criminal sexual conduct in the first through fifth degrees as defined in sections 609.342 to 609.3451.
A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.
(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:
(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;
(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening;

Vulnerable Adult interviewed: Yes. Both resident #1 and resident #2.
Family/Responsible Party interviewed: No. Multiple attempts were made to contact a responsible party for both resident #1 and resident #2.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
During the facility's investigation resident #1 was sent to the hospital for an evaluation, and staff was re-educated on abuse and reporting abuse. The AP was no longer employed by the facility.

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		