Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL294088925M
Compliance #: HL294086398C

Date Concluded: December 21, 2023

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: Deb Schillinger, 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 administered incorrect medications to the resident.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although the resident was given incorrect medications, the error was an isolated incident, and no harm occurred to the resident and returned to their baseline health condition.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed caregivers. The investigator contacted the resident's family member. The investigation included review of resident records, incident reports, internal investigations, employee records and facility policies and procedures. Also, the investigator observed medication administration procedures.

The resident resided in an assisted living memory care unit. The resident's diagnoses included lung cancer and Alzheimer's disease. The resident's service plan included assistance with medication management and administration.

The facility incident report indicated the unlicensed caregiver administered the resident incorrect medications; the unlicensed caregiver immediately reported the medication error to the facility nurse. The resident was transferred to the hospital where she was monitored and returned to facility. The resident remained at her baseline health status.

During an interview, the unlicensed caregiver stated she immediately reported to the RN when she realized the error was made and monitored the resident until transferred to hospital. She reported she was removed from medication passing duties until re-education, both verbal and online classes, completed. She stated that she had not had any similar situation before this error or since.

During interviews, several unlicensed caregivers stated the proper procedure for medication administration was to follow the six rights of medication administration which included identifying the resident before administering medication. Postings of six rights were later placed after the incident on the medication cart for reference.

During an interview, a registered nurse (RN) stated all employees are trained on proper medication administration. The RN stated the unlicensed caregiver immediately notified the nurse when the medication error was identified, the unlicensed caregiver was removed from medication cart duties and re-educated on the medication administration policy. The facility RN stated that all staff were re-educated during the monthly all staff meeting following the incident.

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.

(5) an individual makes an error in the provision of therapeutic conduct to a vulnerable adult that results in injury or harm, which reasonably requires the care of a physician, and:
(i) the necessary care is provided in a timely fashion as dictated by the condition of the vulnerable adult;
(ii) if after receiving care, the health status of the vulnerable adult can be reasonably expected, as determined by the attending physician, to be restored to the vulnerable adult's preexisting condition;
(iii) the error is not part of a pattern of errors by the individual;
(iv) if in a facility, the error is immediately reported as required under section 626.557, and recorded internally in the facility;
(v) if in a facility, the facility identifies and takes corrective action and implements measures designed to reduce the risk of further occurrence of this error and similar errors; and
(vi) if in a facility, the actions required under items (iv) and (v) are sufficiently documented for review and evaluation by the facility and any applicable licensing, certification, and ombudsman agency.

Vulnerable Adult interviewed: Not able, cognitively impaired.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
The facility retrained the unlicensed caregiver on medication administration.

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 10/25/2023

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 September 27, 2023, the Minnesota Department of Health initiated an investigation of complaint #HL294084572C/#HL294087764M No correction orders are issued. On October 25, 2023, the Minnesota Department of Health initiated an investigation of complaint #HL294086398C/#HL294088925M and HL294086397C. No correction orders are issued.	0 000		