Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL294089922M
Compliance #: HL294084800C

Date Concluded: April 6, 2026

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:
Maerin Renee, RN, Special Investigator

Finding: Not Substantiated

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):
AP1 and AP2 emotionally abused the resident when the resident asked for help and AP2 said she was not going to get the resident "shit, ask someone else." When the resident reported the exchange to a supervisor, AP1 and AP2 followed the resident and AP1 told the resident she would show the resident how "hood" she can be.

AP1 physically abused the resident when she physically pushed him for getting "in her space."

Investigative Findings and Conclusion:
The Minnesota Department of Health determined emotional abuse was not substantiated. Although foul language was exchanged between the resident and AP1 and AP2, the language did not meet the statutory definition of abuse. The Minnesota Department of Health determined physical abuse was inconclusive. Although AP1 and AP2 entered a verbal altercation

with the resident, written and verbal witness accounts varied regarding a physical altercation. AP1 and AP2 denied hitting or pushing the resident.

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, the facility internal investigation, facility incident reports, personnel files, staff schedules, law enforcement report, and related facility policy and procedures. Also, the investigator observed resident cares and staff interactions with residents.

The resident resided in an assisted living facility. The resident's diagnoses included Parkinson's disease and adjustment disorder with mixed anxiety and depressed mood. The resident's services included assistance with bathing, meals, housekeeping/laundry, and medication management. The resident's assessment indicated the resident had mild depression and poor decision-making skills. Staff were to carry out behavioral interventions set by nursing.

The facility's internal investigation indicated AP2 was on her break when the resident requested a dinner plate and a soda. AP2 informed the resident she was on break and said, "I'm not getting you shit." The resident reported the interaction to a nurse. AP1 and AP2 followed the resident to the nurse office. A nurse attempted to de-escalate the situation and went to get the resident the soda he originally requested. After leaving the nurse office, a physical altercation occurred involving pushing/shoving and swearing/threats between the resident and AP1 and AP2. One AP (the document did not indicate whether it was AP1 or AP2) pushed the resident because she said she felt threatened, and AP2 told the resident she would "show him how ghetto she could be." AP1 said she "would beat his ass." During the interaction, the resident made contact with AP2's hand, resulting in her fingernail being bent and broken off. Staff called law enforcement. The investigation summary concluded "staff" (it did not indicate AP1 or AP2, or both) pushed the resident and refused service to a vulnerable adult in their care. AP2 went to the hospital with a finger injury and AP1 left because she felt threatened.

The resident's progress notes indicated the resident presented to the nursing office visibly upset, stating a staff member would not give him a coke. After a nurse got the resident a coke, he and AP1 and AP2 left the nurse office. Outside the nurse office the resident and AP1 and AP2 became verbally aggressive. The resident approached AP1 and AP2 and physical contact occurred, with shoving observed between the resident and AP1 and AP2. A nurse intervened and positioned herself between the resident and AP1 and AP2 to stop the altercation. AP2 sustained a broken fingernail. Staff called law enforcement. AP2 went to the hospital to address her broken fingernail, and AP1 left the facility. It was determined both AP1 and AP2 used threatening language toward the resident and engaged in physical contact by placing their hands on him.

Disciplinary records indicated both AP1 and AP2's employment at the facility was terminated due to "substantial employee misconduct." Neither AP1 nor AP2 were eligible for rehire, due to

the nature of the incident. A physical altercation occurred involving pushing/shoving and swearing/threats between the resident and AP1 and AP2. During the internal investigation, facility leadership determined both AP1 and AP2 threatened the resident, saying, “I’ll show you how hood I can be,” and “I’ll beat his ass.” Both AP1 and AP2 put hands on the resident.

Training documents indicated both AP1 and AP2 received training in communication skills including preserving the dignity of the client and showing respect for the client; understanding appropriate boundaries between staff and clients; recognizing physical, emotional, cognitive, and developmental needs of the client; the assisted living bill of rights; and mental illness.

A police report indicated the incident between the resident and AP1 and AP2 began over a can of soda. The situation continued to escalate because AP1, AP2, and the resident were upset with each other. AP2 reported that the resident complained to the nurses that she would not help him. AP2 said she followed the resident to the nurse office and continued to argue with him. AP2 said the resident pushed AP1, so AP2 put her hand between AP1 and the resident. The resident’s hand made contact with hers and broke one of her fingernails.

The police report indicated AP2 said the resident had come to the cafeteria to grab a second dinner tray, and AP1 and AP2 said he could not take a second tray. The resident asked AP1 for a can of soda, and they advised him to wait. The resident went to complain about AP1 and AP2 to the nurses, and AP1 and AP2 followed him to the nurse office. AP1 said she “got in” the resident’s face and cursed at him. AP1 said the resident came out of the office and got in her face. AP1 said the resident pushed her and AP2. As the resident walked away, AP1 told him she would show him how “hood I am.” AP1 said if the resident approached her again, she would “beat his ass.”

The police report also included the resident said AP2 pushed him first, and he pushed her back, at which point she broke a fingernail. The resident said AP1 was pointing at him, and AP2 pushed his hand. He said he pointed at her, and AP2’s hand caught his hand, and her nail fell off. When asked why there had been any physical altercation, the resident said he reported AP1 and AP2’s behavior to the nurses, and they came into the office to confront him. A second nurse said she saw AP1, AP2, and the resident pushing back and forth. She put herself between the three to intervene. No criminal charges were filed.

When interviewed, a supervisor said the facility houses residents who display behaviors, and staff are trained on how to manage behaviors when they occur. In this case, AP1 and AP2 did not respond in an appropriate, professional manner when the resident became aggravated. At one point, AP1 was yelling at the resident, so AP2 put her hand between them and made contact with the resident’s hand, breaking off AP2’s fingernail. It was reported to the supervisor that AP1 and AP2 and the resident were pushing each other back and forth. A nurse who tried to intervene got pushed as well, but she did not know by whom.

When interviewed, a nurse said she tried to de-escalate the situation and redirect the resident while another nurse got the resident the soda he had asked for. AP1 and AP2 were verbally aggressive toward the resident. The resident left the nurse office, and the interaction between the resident, AP1, and AP2 escalated. During the physical altercation, the nurse saw the resident and AP2's hands hit "or something like that." AP2 broke a fingernail, for which she was taken to the hospital. The nurse said the resident maybe got pushed, but she was not sure of the details. If the resident did get pushed, the nurse did not know by whom. The nurse was unaware of any injuries the resident might have sustained.

When interviewed, the resident said AP1 and AP2 liked to pick on people and were treating him badly, so he reported their behavior to a nurse. AP1 and AP2 followed him to the nurse office and started yelling at him. AP2 was yelling at the resident, pointing her finger in his face, so he pointed his finger at AP2. AP1 pushed the resident's hand away, in the process breaking a fingernail. AP1, AP2, and the resident began to push and hit each other, so a nurse got between them to try to stop the physical altercation. After the nurse stopped the altercation, the resident went back to his room.

When interviewed, AP1 said the resident had been belligerent toward her and AP2 since the start of their shift. The resident used derogatory language toward AP1 and AP2 and then went to the nurse office to file a complaint against them. After he left the nurse office, AP1 and AP2 entered into a verbal altercation with the resident, which escalated. The resident came toward AP1. AP1 placed her hand on the resident's chest and asked him to step back from her. AP1 said the resident then pushed her backward. AP1 said she did not hit or push the resident. The resident then grabbed AP2's hand and bent her fingers backward, breaking off a nail. A nurse came out of the office and physically separated the three of them.

When interviewed, AP2 said the resident had been calling AP1 and AP2 names and racial slurs throughout their shift. After the resident complained to the nurses about AP1 and AP2, the three entered a verbal altercation that escalated to a physical altercation. The resident pushed AP1, and AP1 placed her hand on his chest to prevent him from pushing her again, but he pushed her again and AP2 put her hand in between them. The resident pushed AP1 again and grabbed AP2's hand. The resident bent the last three fingers of AP2's hand backward, nearly dislocating one of her fingers. AP2 denied pushing or hitting the resident.

In conclusion, the Minnesota Department of Health determined emotional abuse was not substantiated.

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

"Not Substantiated" means:
An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment did not occur.

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" 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; or
(3) use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion, including the forced separation of the vulnerable adult from other persons against the will of the vulnerable adult or the legal representative of the vulnerable adult unless authorized under applicable licensing requirements or Minnesota Rules, chapter 9544.
(c) Any sexual contact or penetration as defined in section 609.341, between a facility staff person or a person providing services in the facility and a resident, patient, or client of that facility.
(d) The act of forcing, compelling, coercing, or enticing a vulnerable adult against the vulnerable adult's will to perform services for the advantage of another.
(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.
Family/Responsible Party interviewed: No, the resident is his own decision-maker.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility completed an internal investigation. The staff members are 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 02/18/2026

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 February 18, 2026, the Minnesota Department of Health initiated an investigation of complaint #HL294084800C/#HL294089922M. No correction orders are issued.	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. 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. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. 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.	