Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL282047483M
Compliance #: HL282042870C

Date Concluded: February 20, 2025

Name, Address, and County of Licensee Investigated:
Beacon Home of Wedgewood
3610 Mount Vernon Court
Woodbury, MN, 55129
Washington County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Angela Vatalaro, RN
Special Investigator

Finding: Substantiated, facility and individual 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 alleged perpetrator (AP) neglected the resident when the AP failed to follow the resident's plan of care. The resident fell and sustained a fracture. In addition, the AP failed to notify the nurse of the fall and failed to report the resident's complaints of pain after the fall.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The AP and facility staff were responsible for the maltreatment. Although the AP did not transfer the resident with a gait belt according to the service plan, the resident's fall occurred after the transfer when the resident was seated in the wheelchair. Following the fall, the AP failed to notify the nurse of the resident's fall and had complaints of shoulder pain. After the fall, facility staff also failed to call the nurse to report the resident's pain. A day after the fall occurred, facility nursing learned about the resident's fall by the resident's family member. Records indicated the resident complained of left shoulder pain and laid in bed most of the day following the fall.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and the AP. The investigation included review of the resident records, facility internal investigation, facility incident reports, personnel files, video footage, and related facility policy and procedures. Also, the investigator observed the facility.

The resident resided in an assisted living facility. The resident's diagnoses included stroke affecting left non-dominant side. The resident's service plan included assistance with transfers requiring hands on assistance using a gait belt. The resident could stand for five seconds or more, or as long as it took to complete the transfer. At no time would a caregiver "lift" the resident. The resident used a wheelchair. The resident's assessment indicated the resident was alert and oriented and could walk to and from meals using a walker with staff assist using a gait belt. The resident was able to bear weight and maintain balance for the duration of the walk time. The resident was a high fall risk and required assistance with activities of daily living to reduce the risk of falls.

The facility's internal investigation and incident report indicated the resident had a witnessed fall when in the wheelchair, the resident leaned down, fell forward, and hit the ground. The AP's actions of the transfer were recorded on video capture. The AP transferred the resident from her bed to wheelchair without using a transfer (gait) belt. Shortly after, the AP assisted the resident to sit in wheelchair, the resident was seated on the front edge of the chair, which resulted in the wheelchair tipping forward without the wheelchair brakes on. The resident complained of shoulder pain when the AP assisted the resident back to bed, and this could be heard in the video capture. Records indicated the AP reported to the oncoming shift of the residents fall, filled out an incident report, however, did not call the on-call nurse about the incident. The AP had attended staff training regarding fall incident reporting protocols. The AP told leadership he did not call the on-call nurse because there was no immediate emergency. The next day, staff said the resident had some left shoulder and hip pain and spent most of the next day in bed. Oncoming staff thought the AP had already reported the fall to the on-call nurse due to the fact the AP witnessed the fall and filled out the incident report. A day later nursing was made aware of the resident's fall and an x-ray was ordered. The resident had a broken left clavicle (collarbone).

Facility internal investigation records indicated staff had received retraining on the facility's fall incident and reporting protocol four days prior to the resident's fall.

Resident records indicated the resident had a witnessed fall and complained of shoulder pain when she yawned and moved her arm. A portable x-ray was ordered and showed a broken clavicle (collarbone) which could be treated conservatively, and an orthopedic appointment was scheduled for any other treatment options. Orthopedic visit records indicated orders for acetaminophen (Tylenol), use of a sling, and no surgery indicated at that time. Records indicated the facility contacted the resident's provider for pain medication after the fall.

During an interview, a nurse stated the resident's family member reported the fall to her a day after it occurred. Nursing was not made aware of the fall by staff. A nurse assessed the resident, and a portable x-ray was ordered. The resident had a fractured clavicle. The nurse stated she watched recorded video of the AP transferring the resident into her wheelchair without using of a gait belt. After the transfer, when seated in the wheelchair, the resident was not seated all the way back, the wheelchair tipped, and the resident fell out. After the fall, the AP asked the resident if she was okay which the resident replied yes. The nurse said the resident also told the AP that she had pain. The AP did not call the nurse. The resident's fracture was treated non-surgically, and pain medications were ordered. The nurse said the resident had no recent history of falls; the last fall occurred a year prior to this incident. The nurse said the AP and facility staff received training to call a nurse after a fall and prior to getting any resident up off the floor.

During an interview, the AP stated the resident's fall did not occur because of the transfer, the fall occurred because the resident was not seated all the way back in the wheelchair, and the resident fell out of the chair. The AP said he did not notice the resident was not seated all the way back after he completed the transfer and said the resident would normally push herself all the way back when seated. The AP denied the resident complained of shoulder pain after the fall. The AP stated he did not call the nurse to report the fall because the fall was not a serious emergency, he was confused from his training on falls, and said he thought filling out the incident report was notifying the nurse. The AP said he was told afterwards he should have contacted the nurse immediately.

During an interview, a family member stated she spoke to the resident the day after the fall occurred. The resident said she had fallen, had shoulder pain, and the resident said she had told facility staff about the pain. The resident said her shoulder hurt when she yawned. The family member contacted a nurse, who was unaware the resident fell.

In conclusion, the Minnesota Department of Health determined neglect was substantiated.

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: No. Unable due to cognition.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility obtained orders for an x-ray and communicated with the resident's provider. The facility conducted an internal investigation. The AP is no longer employed by the facility.

Action taken by the Minnesota Department of Health:
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

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Washington County Attorney
Woodbury City Attorney
Woodbury Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28204	A. BUILDING: _____ B. WING _____	C 01/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON HOME OF WEDGEWOOD	3610 MOUNT VERNON COURT WOODBURY, MN 55129

(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 ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. 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. INITIAL COMMENTS: #HL282041540C/#HL282046982M #HL282042870C/#HL282047483M On January 29, 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 19 residents receiving services under the provider's Assisted Living license. For #HL282041540C/#HL282046982M. No correction orders are issued. The following correction order is issued issued for #H282042870C/#HL28047483M, tag identification 2360.	0 000		
02360	144G.91 Subd. 8 Freedom from maltreatment	02360		

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02360	Continued From page 1 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. This MN Requirement is not met as evidenced by: The facility failed to ensure one of two residents reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility and individual person were responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		