Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL306528164M
Compliance #: HL306525282C

Date Concluded: April 3, 2024

Name, Address, and County of Licensee Investigated:
Beacon Home of Belmont
1355 Mendota Heights Road
Mendota Heights, MN 55120
Washington County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: James P. Larson, RN
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 facility neglected the resident when staff failed to follow doctor's orders with medication administration, failed to develop and implement interventions concerning weight loss, and failed to provide medical care as needed.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. There were conflicting accounts surrounding the details of the concerns reported and records reviewed did not reflect if the care received, or a lack of care, contributed to the disease process or any complications experienced by the resident.

The investigator conducted interviews with facility staff members. The investigator also contacted the resident's family and hospice agency staff. The investigation included review of the resident's medical records, hospital records, death record, and facility policies and

procedures. At the time of the onsite visit, the investigator toured the facility and observed staff to resident interactions.

The resident resided in an assisted living facility. The resident's diagnoses included traumatic brain injury (TBI) with spinal cord injury, left sided hemiplegia (a weakness on one side of the body) and cholecystectomy (surgical removal of the gallbladder). The resident's service plan included assistance with medication management, bathing, housekeeping, laundry, and meals. The resident's assessment indicated his cognition was moderately impaired and required cues and supervision.

Complaint documents identified concerns surrounding the facility's provision of care and general services, treatments, medication administration, and weight loss.

Review of the resident's medical record and facility documentation identified care was provided as directed by the resident's physician and in accordance with the resident's service plan. The resident's medical record identified the resident had dysphagia (difficulty swallowing) and required nectar thick liquids; staff monitored the resident's meal intake and offered nutritional supplements as needed. The resident's medical record also indicated the resident's weight fluctuated over the past year, although in the months leading up to the resident's death, his weight remained stable.

Months before the resident's passing, facility staff reported to the nurse that the resident had a fever resistant to treatment in the facility and the resident was sent to the hospital for further evaluation. The resident was admitted and treated for sepsis (an infection). After being released from the hospital, the resident's care team recommended hospice care. The resident returned to the facility and passed away five months later.

During discussion with hospice agency staff, hospice staff indicated they assessed the resident upon admission to their care, which included review of the resident's nutrition and intake. Hospice staff indicated a plan of care was developed and the appropriate steps were taken to address the resident's disease progression and nutritional concerns.

During an interview, a facility nurse stated that staff made additional efforts to work with the resident's care team and hospice team and followed all recommendations as ordered.

During an interview with the resident's family member, they indicated that the overall care provided was sufficient, but voiced concerns about the care provided in the months leading up to the resident's death.

Additional family members were contacted and declined to be interviewed.

In conclusion, the Minnesota Department of Health determined neglect 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.

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, deceased.
Family/Responsible Party interviewed: No, declined.
Alleged Perpetrator interviewed: No.

Action taken by facility:
The facility followed orders from the care team throughout the resident’s facility stay and conducted care conferences to discuss and address concerns related to the resident’s care.

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.

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
	30652	A. BUILDING: _____ B. WING _____	C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON HOME OF BELMONT	1265 BELMONT DRIVE WOODBURY, MN 55125

(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: #HL306525282C/ #HL306528164M On March 6, 2024, 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 4 residents receiving services under the provider's Assisted Living license. The following correction order is issued/orders are issued for #HL306525282C/ #HL306528164M, tag identification 1760.	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	

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0 000	Continued From page 1	0 000	ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure medications were administered as ordered for one of one resident (R1). 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). The findings include:	01760		

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01760	Continued From page 2 R1's diagnoses included traumatic brain injury (TBI) with spinal cord injury, left sided hemiplegia and cholecystectomy. R1's started receiving services from the licensee on October 21, 2013. R1's service plan dated August 1, 2023, included assistance with activities of daily living (ADLs), medication management, bathing, housekeeping, laundry, and meals. R1's July 2023 medication administration record (MAR) included: RISPERIDONE TAB 0.5MG 1 TABLET ORALLY TWICE A DAY (DX:AGITATION). The MAR included an entry on July 1, 2023, at 8:00 a.m. to hold RISPERIDONE TAB 0.5MG, and in the explanation box indicated, "Held per wife this morning". Additional entries on the MAR indicated that Risperidone Tab 0.5mg were given as ordered on July 1, 2023 8:00 a.m. and again on July 2, 2023 at 8:00 a.m. R1's scheduled Risperidone medication was not administered after the scheduled dose beginning on July 2, 2023 at 8:00 p.m. Further review of the electronic health record (EHR) progress notes indicated an entry by RN-C on July 3, 2023 at 8:49 a.m. which indicated, "Staff called RN and said that power of attorney (POA), requested to HOLD rispirodine. RN noted per POA that was her choice and that was okay to hold for the night 7/2/23. RN called POA 7/3/23 at 0830 hours to inquire if wanted to d/c medication, keep on hold to monitor. RN emailed care team to monitor for w/d side effects. RN also noted would f/u with PCP after POA called RN back about medication". An additional entry by RN-C dated July 5, 2023 at 4:19 p.m. indicated, "Family spoke with RN Monday 7/3/23 noted HOLD	01760		

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01760	Continued From page 3 risprodone until further notice. Noted RN would f/u with primary care provider (PCP) to advise. Noted RN placed medication on HOLD". On March 26, 2023, registered nurse (RN)-C was interviewed and confirmed she made the entrees in R1's progress notes in reference to hold the medication, but did not recall if there was a physician order obtained directing staff to hold the medication. RN-C confirmed the facility policy would be to follow physician's orders for all medication administration or witholding of medication. The licensee's Medication Administration policy dated November 1, 2023, stated once verified, the medication will appear or be removed based on orders. The medication administration record will then be reflective of the health care providers updated orders. No further information was provided. TIME PERIOD FOR CORRECTION: Seven days (7) days	01760		