Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL37996003M
Compliance #: HL37996004C

Date Concluded: October 10, 2022

Name, Address, and County of Facility Investigated:
Belevo Health Services LLC
1064 Dale Street
St. Paul, MN 55117
Ramsey County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Lori Pokela R.N.
Special Investigator

Finding: Inconclusive

Nature of Visit:
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.

Allegation(s):
It is alleged neglect occurred when the resident broke into the facility nursing office, then proceeded to get into a locked medication locker when he proceeded to ingest three days' worth of his own medications before becoming lethargic and being transported to the hospital.

Investigative Findings and Conclusion:
Neglect was inconclusive. Three days' worth of the resident's own medications went missing from a locked medication locker kept in the facility nursing office. Even though the resident had admitted to climbing through the nursing office [ground floor]window, the nursing office door may have been unlocked and the nursing office unattended by staff for an unspecified amount of time at the time the resident's medications went missing. The day after the resident's medication's went missing, the resident became lethargic and was transported to the hospital.

The investigation included interviews with facility staff members, including; administrative staff, nursing staff, and unlicensed staff. The investigation included observation of the nursing office, nursing office window, locked medication locker, medication key storage areas, locks on the nursing office door and medication locker. The resident's medical records were reviewed, as well as facility pertinent policies.

The resident lived in an assisted living facility. The resident's diagnoses included antisocial and borderline personality disorder. The resident's service plan included daily staff assistance with medication administration, bathing, walking, meal preparation, housekeeping, behavior monitoring and medical appointment set-up. The resident's nursing assessment indicated the resident needed assistance when climbing stairs and a history of falls.

The resident's individual abuse prevention plan (IAPP) indicated a risk agreement was established for harm reduction and staff would monitor the resident's risky behaviors regarding prescription medications.

A facility incident report indicated an unlicensed staff went into the facility nursing office to administer the resident's afternoon medications and found the medication was missing. This same document indicated the unlicensed staff member called the administrative staff after the missing medications were discovered and could not be found.

During an interview, a facility nursing staff stated, after the medications went missing the resident's room was checked but not found. This nursing staff member stated it was unclear how the medications went missing as the nursing office had been locked and the keys for the medication lockers, [kept in the nursing office}, we kept in an unlocked container in the same office.

During an interview, a facility administration staff stated when the resident was in the hospital, he had told her that he went through the nursing office window and took the medications. This administrative staff stated that after the incident, there were footprints observed on an uninstalled air conditioning unit, kept on the ground, outside the nursing office window. The administrative staff stated she was unsure whether window was locked at the time of the incident, but after the incident, the window was observed to have a scrape on the frame.

During an interview, a facility management staff stated medications for the residents are usually kept in locked medication closets that are in the resident's apartments. The management staff stated, because the facility had been made aware of the resident's history prior to admission, the facility decided to keep the resident's medications in the locked, locker that was stored in the locked facility nursing office. The management staff stated all facility staff were alerted upon the resident's admission, to give as much one-to-one activity as their schedules would allow.

During an interview, an unlicensed staff who was working the day of the incident, stated after returning to the facility nursing office, she observed the door had been unlocked. The unlicensed staff stated being gone approximately 30 minutes, when she went back into the nursing office, proceeded to take the medication locker key, [kept near the nursing office desk in an unlocked container], and open the resident's locked medication locker. Upon opening the locker, she observed the resident's medication missing. She then asked the resident if he had taken his medications to which the resident stated: "no". The unlicensed staff member then called the nursing and administrative staff immediately. The unlicensed staff member stated, prior to her leaving the office earlier that day, she remembered leaving the nursing office with painters working inside that location and when she returned to the nursing office the painters were no longer there. This unlicensed staff member also stated there was an air conditioning unit inside the nursing office just under the window.

In conclusion, 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.

Action taken by facility:
The facility completed an internal investigation, re-education regarding locking the nursing office and medication lockers. In addition, the facility re-located the nursing office medication locker keys.

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
	37996	A. BUILDING: _____ B. WING _____	C 09/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
1-BELEVO HEALTH SERVICES LLC	1064 DALE STREET NORTH SAINT PAUL, MN 55117

(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 Initial comments On September 15, 2022, the Minnesota Department of Health initiated an investigation of complaint #HL37996004C/#HL37996003M. No correction orders are issued.	0 000		