Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment #: HL259003741M
Compliance #: HL259004181C

Date Concluded: September 4, 2024

Name, Address, and County of Licensee Investigated:
Beacon Home of Eagan
3808 Blackhawk Ridge Place
Eagan, MN 55122
Dakota County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name:
Maerin Renee, 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 alleged perpetrators, AP1 and AP2, neglected the resident when AP1 and AP2 refused to get the resident out of bed for two days.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. The resident initially reported staff did not get her out of bed all weekend. Due to conflicting information, it could not be determined if the resident was left in bed by AP1 and AP2 for the entire weekend.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident records, medication records, the facility internal investigation, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed staff interactions with resident, including physical cares.

The resident resided in an assisted living facility. The resident's diagnoses included multiple sclerosis. The resident's services included assistance with activities of daily living such as bathing, dressing, and transfers, meals, medication management, housekeeping, and laundry. The resident's assessment indicated the resident was alert and oriented and required the use of a wheelchair and full body lift for transfers and ambulation.

The facility internal investigation indicated the resident told a visiting nurse staff did not help the resident get out of bed all weekend. The resident said staff told her they were busy and short-staffed. The manager reviewed the schedule for that weekend and determined the facility had sufficient staff to meet the needs of the residents. The manager stated she talked with AP1 and AP2 about the weekend, and they said they had a busy weekend related to helping another resident and their family. The manager noted AP1 documented she assisted the resident get out of bed on Saturday.

The internal investigation indicated AP1 stated the resident wanted to sleep in for most of the morning shift and did not want to get out of bed until after noon. On Saturday, the resident stayed in bed because there were, "only two staff" working. AP1 said one staff member was helping residents and the other was passing medications. AP1 and AP2 considered two staff scheduled to work as short-staffed, but they did not attempt to contact a supervisor for support. On Sunday, AP1 stated she and AP2 helped the resident get out of bed in the afternoon when the resident was ready to get up.

The internal investigation indicated AP2 stated she and AP1 helped the resident out of bed on Sunday. On Saturday, AP2 said they were short-staffed and too busy with other residents, so they did not have time to help the resident get out of bed. AP2 said she and AP1 still helped the resident with her other cares, such as changing her briefs and clothes. AP2 stated the resident was fine staying in bed since staff were busy.

The internal investigation indicated the resident recalled spending one day in bed that weekend. The resident stated staff told her they were "really busy" and the resident said she was "comfortable and didn't care if [she] stayed in bed." The resident said she was willing to stay in bed when staff are overworked.

The resident's service list indicated AP1 signed off on helping the resident out of bed on Saturday morning and AP2 signed off on helping the resident out of bed on Sunday morning. AP2 signed off helping the resident into bed on both Saturday and Sunday on the PM shift.

The resident's 24-hour report indicated on Saturday's day shift AP1 documented the resident's status was "good." The evening shift documented "family visited." On day shift Sunday, AP2 documented the resident was in her room with her husband watching television. The resident was in bed because she did not get much sleep. Evening shift staff documented the resident was, "in room watching TV."

When interviewed, AP1 said they were short-staffed and the resident was tired, so she asked to stay in bed longer than usual so she could get some rest. AP1 said the resident did not stay in bed all day Saturday because she and AP2 got the resident out of bed when she was ready. On Sunday, AP1 said she and AP2 were preoccupied with another resident so they did not get the resident up at her usual time, but they did eventually help her out of bed.

When interviewed, AP2 said she and AP1 got the resident out of bed late on Saturday because the resident said she was tired and wanted to sleep in. AP1 and AP2 helped the resident get out of bed later that day when the resident was ready. AP2 did not remember anything about Sunday but said the resident got out of bed that day as usual.

When interviewed, a visiting nurse said she saw the resident on Monday. During that visit, the resident told her it was the first time she had been out of bed since Friday. The resident told her she asked to get out of bed, but staff told her they were too busy and would get her up closer to lunch. Around lunchtime, the resident asked to get out of bed again, but AP1 and AP2 told her they would just have to put her right back into bed after lunch, so there was no point in getting her up. The resident told the visiting nurse she was in bed from Friday night until just before the community nurse came to visit her. The resident did not appear upset, fearful of staff, nor did she complain of increased pain.

When interviewed the resident stated, “I just didn’t want to get out of bed that day, that’s that. There is your interview.”

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: Yes.
Family/Responsible Party interviewed: No, did not respond to interview requests.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility completed an internal investigation and retrained staff regarding resident cares.

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
	25900	A. BUILDING: _____ B. WING _____	C 08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON HOME OF EAGAN	3808 BLACKHAWK RIDGE PLACE EAGAN, MN 55122

(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 August 13, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL259004181C/#HL259003741M. 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.	