Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL259005283M
Compliance #: HL259007228C

Date Concluded: January 17, 2025

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: Christine Bluhm, RN
Special Investigator

Finding: Substantiated, 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:
The alleged perpetrator (AP) abused the resident when the AP used a blanket to tie the resident to her wheelchair which prevented the resident from standing.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was substantiated. The AP was responsible for the maltreatment. The AP admitted she tied a bedsheet around the resident's waist and the back of the wheelchair to prevent her from rising. The AP stated it was done to keep the resident safe while she assisted another resident.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's case worker. The investigation included review of the resident record, facility internal investigation, facility incident reports, personnel files, staff schedules, and related facility policy and procedures Also, the investigator observed staff interactions with residents at the facility.

The resident resided in an assisted living facility. The resident's diagnoses included Parkinson's disease and dementia. The resident's service plan included assistance with all activities of daily living and medication administration. The resident's assessment indicated the resident was a fall risk, had balance problems when standing and was disoriented most of the time. The assessment indicated staff were to engage with the resident with activities when there was down time.

A concern arose the resident had been tied down in a chair using a sheet. When this was discovered, a photo was taken to document what was found and provided to the facility.

The investigation included a review of a photo which showed the resident with a blanket tied around her waist and seated in the wheelchair.

The facility incident report indicated alleged abuse occurred when a staff member [the AP] used a bedsheet to tie the resident to her wheelchair. The incident report indicated the AP restrained the resident in an attempt to keep the resident from getting up from the wheelchair. The resident was assessed, and no physical injuries were noted.

During interview, the AP stated she and the other unlicensed caregiver were caring for a second resident that required two staff for cares when the resident was in the dining room by herself. The AP stated the resident did not want to stay seated in the recliner or wheelchair so she tried other interventions with the resident such as coloring activity, music and even placed another wheelchair behind her so she would not get up and fall while in her wheelchair. The AP stated she then grabbed a fitted sheet out of the closet and tied it around the resident's waist and around the back of the wheelchair and finished with the other resident. The AP stated when they finished cares for the other resident and came out of the room, the resident was still tied up and continued to be tied up while the AP prepared lunch. The AP stated the resident was then untied when the resident needed to use the restroom.

The facility issued the AP a corrective action, which indicated the AP admitted she tied the resident to the chair because she was caring for another resident at the time. The corrective action included the AP's signature. The same document indicated the other unlicensed caregiver stated the resident, who the AP claimed to have been caring for, was out of the building at the time the resident was tied to the wheelchair.

During an interview, a manager stated timestamps of the camera footage and photos did not corroborate and were inconsistent with the AP's narrative.

During an interview, a nurse stated it was not okay to use a restraint. The nurse stated all staff were educated on resident's rights and vulnerable adult policies following the incident.

In conclusion, the Minnesota Department of Health determined abuse 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.

Abuse: Minnesota Statutes section 626.5572, subdivision 2.
"Abuse" means:
(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:
(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.

Vulnerable Adult interviewed: No.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility: The facility reviewed resident’s rights and facility policies to all staff. The AP no longer worked at the facility.

Action taken by the Minnesota Department of Health:
The facility was issued a correction order regarding the vulnerable adult’s right to be free from maltreatment.

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

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
Dakota County Attorney
Eagan City Attorney
Eagan Police Department

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 01/02/2025

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 January 2, 2025, the Minnesota Department of Health investigated an allegation of maltreatment, complaint #HL259005283M/HL259007228C, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. The following correction order is issued/orders are issued for #HL259005283M/HL259007228C, tag identification 2360.	0 000	Assisted Living Provider 144G. 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.	
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 one resident reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, an individual person was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		