Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL282046982M
Compliance #: HL282041540C

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: Not Substantiated

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 provide supervision, and the resident attempted suicide by hanging. The resident sustained a fracture and hospitalized.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. There was not a preponderance of evidence to support the facility could have reasonably anticipated the resident would attempt self-harm by suicide. Staff followed the resident's plan of care, provided a safety check before the incident occurred, and reported the resident showed no signs of distress prior to the incident. Two nurses both stated the resident denied having any thoughts of self-harm or suicidal ideation during his stay at the facility.

The investigator conducted interviews with facility staff members, including administrative staff and nursing staff. The investigation included review of the resident records, hospital records,

facility internal investigation, facility incident report, and related facility policy and procedures. Also, the investigator toured the facility.

The resident resided in an assisted living facility for two months. The resident's diagnoses included mental health diagnoses. The resident's service plan included assistance with medication management. The resident's assessment indicated the resident was independent with walking and transferring. Prior to admission to the facility, the resident had a history of suicidal ideation. Measures taken to prevent self-abuse included medication management services to ensure treatment for mental health conditions, and safety checks due to a fall risk and history of risk for injury of self. The resident was oriented, able to communicate, able to make his needs known, independent with using a phone and independent with a call system. The resident isolated, spent the majority of his time in his apartment, and needed encouragement to attend activities.

Records indicated one day between 4-4:30 p.m., the resident's door was cracked open, and staff stated they did not hear any signs of distress from the resident. Between 4:30-5:00 p.m., two staff members were across the hall from the resident's room providing a different resident a shower. They stated they did not hear anything while across the hall. At 4:45 p.m., the resident's call light went off, at 4:50 p.m., staff responded. The resident was seen sitting on his bed holding his arm and stated, "I tried to hang myself and I think I broke my arm." One staff went upstairs to call the nurse, and another staff member stayed with the resident to ensure he was safe, 911 was called. At 5:05 p.m., emergency medical services (EMS) arrived.

Records indicated the day of the incident a staff member stated the resident was checked on every 2-3 hours. Around 1:00 pm., staff encouraged the resident to go to lunch, he chose not to go, and staff brought the resident his lunch meal to his room. Later in the afternoon when staff responded to the resident's call light, the resident's desk chair was pulled back from the desk, the lift hook from the ceiling was between the desk and the door, and a grey exercise band was broken and beside the resident on the bed. The resident stated he attempted to hang himself by attaching an exercise band to the hook on the ceiling lift. When he stepped off the desk chair, the band broke and the resident fell to the ground. The resident was shaking "like he was scared."

Emergency medical records indicated upon arrival, the resident was found sitting on his bed, alert, oriented, in no obvious distress. Facility staff stated the resident attempted to hang himself using an exercise band while standing on a chair. The resident fell to the floor and landed on his right arm. The resident felt like his arm was broken.

Hospital records indicated the resident admitted for a right shoulder fracture repair and psychiatry evaluation. The hospital record indicated the resident denied any previous suicide attempts.

Scheduled services records indicated the resident received his scheduled safety checks.

Resident records indicated the facility communicated with the resident's providers during his stay and mental health medication changes were made.

During an interview, a nurse stated she received a call from staff that the resident tried to hang himself from a ceiling lift clip and fell. The resident used an exercise band around the clip, put it over his neck, and stood on his desk chair. When the resident dropped down off the chair, he fell to the floor. After the fall, the resident got up, sat on the edge of his bed, used his call pendent, and staff responded. 911 was called.

During an interview, another nurse stated the resident was on medications for depression. The resident was seen in the emergency room for increased anxiety and received medication. The nurse said this was not a change, the resident had a lifelong pattern of treatment for anxiety. The resident preferred to stay in his room. Staff encouraged him to get out of his room and go to meals. The facility offered alternative room placement on the campus which would allow for more socializing, offered activities, attempted to determine activities the resident may enjoy in the community; however, the resident chose not to participate. The nurse said she spoke to the resident about risk of self-harm, thoughts of self-harm, and the resident repeatedly denied thoughts and denied any plan to self-harm. The nurse said staff checked on the resident during the shift, and staff were available to the resident whenever the resident needed them.

During an interview, an additional nurse said the resident had a history of mental illness and required a lot of encouragement to come out of his room. The nurse said the resident was doing well, stable, and at some point, things shifted, and the resident had suicidal ideation. The nurse said she spoke with the resident during his stay. The resident never reported any thoughts of suicidal ideation. When she spoke to the to see how things were going the resident would say everything was "fine" and everything was "good."

During an interview, leadership stated she conducted an internal investigation. The resident had an exercise band in his room at the time, because he was participating in physical therapy. The facility had ceiling lifts in resident rooms which had a ring/clip on the ceiling. The day of the incident, staff on shift stated they did not hear any signs of distress or anything concerning when near his room. Staff reported they saw the resident that day and had delivered him his food as he chose not to come out for the meal. The resident's room door was cracked open. The resident used his call pendent after he fell to the ground. Leadership stated the resident showed signs of depression which he had since admission. Leadership said he showed nothing that would indicate a suicide attempt. The resident was seeing a therapist, nursing was monitoring him, and there was no indication he was that distraught where he would attempt to take his own life. The resident discharged from the hospital to a different facility.

During an interview, a family member stated the resident was seen in the emergency room weeks prior to the suicide attempt for anxiety, was treated with medication, which helped, and the resident improved.

In conclusion, the Minnesota Department of Health determined neglect was not substantiated.

“Not Substantiated” means:
An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment 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. Unable due to cognition.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility attempted interventions for the resident’s isolation and maintained contact with the resident’s mental health providers for medication adjustments. The day of the incident, staff responded to the resident’s call light and sat with the resident until EMS arrived.

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
	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		