

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL357175004M
Compliance #: HL357176742C

Date Concluded: December 30, 2024

Name, Address, and County of Licensee

Investigated:

Butterfly Bound Care
3501 62nd Avenue North
Brooklyn Center, MN 55429
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name:

Katie Germann, RN, Special Investigator

Finding: Substantiated, facility 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(s):

The resident was neglected when the facility failed to provide supervision and three unknown males came to the facility and physically assaulted the resident.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The resident's girlfriend, who was staying at the facility but was not a resident, had a car towed to the facility. Three unknown males who were in a dispute with the resident's girlfriend regarding ownership of the car came to the facility to confront the resident and his girlfriend. The three males physically assaulted the resident. Although the resident required 24-hour staff supervision, there were no staff present at the facility at the time of the assault. The resident's girlfriend called 911. The resident sustained multiple injuries to his right and left shoulder, head, and had a nosebleed.

The investigator conducted interviews with facility staff members, including administrative staff and unlicensed staff. The investigation included review of medical records, employee files, facility policies and procedures, and the police report. Also, observations were completed at the facility.

The resident resided in an assisted living facility with diagnoses including epilepsy and Parkinson's disease. The resident's service plan included assistance with bathing, dressing, housekeeping, laundry, and medication reminders. The resident's assessment indicated the resident had some difficulty ambulating and seizures.

A police report detailing the incident indicated the police were contacted after the resident had been assaulted by three individuals. The report indicated law enforcement observed the resident with injuries on his right and left shoulders, his head, and blood on his nose in his left nostril. The resident told police he was in bed when his girlfriend told him someone was banging on the door and asking for him. The individuals were at the facility regarding a vehicle which had been given to the resident by his girlfriend's mother. The resident opened the door and began to walk out, but he got stuck between the left side of the screen door frame and the door itself. One of the male individuals began pushing on the door and began punching the resident close handed with his right hand. The report indicated the resident recalled being punched two times in his head but does not recall much else. The report indicated the resident's girlfriend stated one of the individuals grabbing the resident by the neck and the other two started punching the resident. The resident fell down the steps and was unconscious for several seconds. The resident's girlfriend contacted the police. The police offered the resident to go to the hospital, but he refused. The report indicated when the assault took place no staff was in the facility. The report indicated there were a total of 3 houses on the same block the staff member was working at one of the other homes at the time of the assault.

A facility investigation of the incident indicated three men and one woman came to the house and when the resident went out to meet them, they started hitting him. The individuals went to the vehicle and tried to start it, but it would not start because the resident had disabled the vehicle.

The facility staff schedules indicated there was one staff assigned to the facility during the time of the incident. The other facilities on the same street each had different staff members assigned during the time of the incident.

A daily shift report from the day of the incident was initialed by a facility staff member indicated the resident had four female visitors at the facility when two men came to the facility and banged on the door. The shift report indicated the resident came out of his room with a big stick and started fighting. The report indicated the police came and the resident spoke with them, and the supervisor was contacted by the report writer.

During an interview the facility administrator stated the vehicle had been brought to the facility after the resident's girlfriend sold the vehicle and it had not been paid for. The administrator stated one of the staff contacted her after the individuals arrived at the facility and assaulted the resident. The administrator stated she was across the street and ran over to the facility once she heard of what was happening. The administrator stated the staff who was working was assigned only to that one facility and she was not working at three facilities at one time.

In an interview, the resident stated he was sleeping when his girlfriend woke him up and told him there was somebody at the door for him. The resident stated he went to the door and as soon as he opened it, he was punched and knocked out. The resident stated his knees, shoulders, and the top of his head were all injured. The resident stated when he came to, the individuals were gone. The resident stated there was a staff member initially present at the facility, however, the staff member ran and went screaming down the street.

During an interview, the resident's girlfriend stated the morning of the incident she heard someone at the door yelling for the resident. She told the resident who came to the door and the individuals started hitting the resident. They hit the resident approximately five times and ran away. The resident's girlfriend stated there was a staff member present at the time of the incident, but the staff didn't seem to understand what was happening.

In an interview, the officer responding to the incident stated the resident's girlfriend called 911, and there was no staff on site when they arrived or during the incident. The officer stated it was several minutes after they arrived when a staff member arrived on site.

During an interview, the staff who was on the schedule to work the day of the incident stated they do not recall the incident, and they were not working at the facility during the time of the incident.

In conclusion, the Minnesota Department of Health determined neglect 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.

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: N/A, resident own responsible party.

Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:

The facility reported to the Minnesota Adult Abuse Reporting Center.

Action taken by the Minnesota Department of Health:

The responsible party will be notified of their right to appeal the maltreatment finding.

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

Hennepin County Attorney

Brooklyn Center Attorney

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35717	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/16/2024
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NAME OF PROVIDER OR SUPPLIER BUTTERFLY BOUND CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 3501 62ND AVENUE NORTH BROOKLYN CENTER, MN 55429
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(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
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0 000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>ASSISTED LIVING PROVIDER CORRECTION ORDER</p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation.</p> <p>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.</p> <p>INITIAL COMMENTS:</p> <p>#HL357176742C/#HL357175004M</p> <p>On October 16, 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 three residents receiving services under the provider's Assisted Living with Dementia Care license.</p> <p>The following correction orders are issued. Tag identification 2360.</p>	0 000		
02360	<p>144G.91 Subd. 8 Freedom from maltreatment</p> <p>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.</p> <p>This MN Requirement is not met as evidenced</p>	02360		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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02360	<p>Continued From page 1</p> <p>by: The facility failed to ensure one of one resident(s) reviewed (R1) was free from maltreatment.</p> <p>Findings include:</p> <p>The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.</p> <p>No plan of correction is required for this tag.</p>	02360		