Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL367441963M
Compliance #: HL367449746C

Date Concluded: September 3, 2024

Name, Address, and County of Licensee Investigated:
The Beatitudes Homes LLC
3812 Commodore Drive
Brooklyn Center, MN 55429
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Michele Larson, 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 facility neglected the resident when they failed to provide necessary care and services when the resident fell from a mechanical sling lift causing a left hip and femur (intertrochanteric) fracture.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. Although the resident was a quadriplegic and fractured his hip, conflicting information was provided by the resident and the facility therefore, it could not be determined how the resident sustained his injury.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's case manager, family member, and emergency medical technician. The investigation included review of the resident record, hospital record, personnel files, staff schedules, ambulance run report, and

related facility policy and procedures. Also, the investigator observed resident cares and a mechanical sling lift transfer.

The resident resided in an assisted living facility. The resident's diagnoses included quadriplegia (paralysis of all four limbs) and traumatic brain injury (brain injury from a violent blow to the head.) The resident's care plan included assistance with turning, repositioning, and transfers. The resident required maximum assistance of two staff for all transfers and being dressed and undressed. The resident used a mechanical sling lift for transfers and a wheelchair for mobility. The resident responded to yes/no questions to make his needs known and was able to communicate a few words when prompted and given time. The resident was oriented to person, place, and time.

One morning, when facility staff entered the resident's room, the resident was in bed screaming in pain. The resident told staff his body was sore. Staff took the resident's vitals and administered his medications.

The following morning, when facility staff entered the resident's room, the resident was crying and complaining about having too much pain in his body. Facility staff arranged for the resident to be evaluated at a hospital.

The resident's ambulance report indicated the emergency medical staff asked the resident if he fell recently and the resident responded, "last week." When asked if he fell out of bed, the resident replied, "with Hoyer" (mechanical sling lift.). The resident responded "yeah," when the resident was asked a second time if he fell from a Hoyer lift.

The resident's hospital records indicated the resident was diagnosed with an intertrochanteric fracture (type of hip fracture of the upper thigh bone) which required surgery and intravenous pain medications. The resident was able to mouth words, answer some questions, and demonstrate the ability to understand hospital providers when asked how his injury occurred. The resident spent several days in the hospital before being discharged back to the facility.

When interviewed, the emergency transport technician stated the resident told her he was dropped the previous week by facility staff during a mechanical lift transfer. The emergency technician stated the resident did not say many words, but stated his words were clear and understood.

When interviewed, the owner of the facility stated she had no idea how the resident broke his hip and denied facility staff dropped him during a mechanical lift transfer. The owner stated staff were interviewed and all staff denied an incident with the resident falling out of the mechanical sling lift.

When interviewed, the resident's family member stated an emergency technician told the family member the resident was dropped from a lift. The family member stated the owner denied the resident fell from a mechanical sling lift.

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: Unable to interview due to the resident's limited ability to communicate.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: N/A

Action taken by facility:
The facility sent the resident to the hospital for treatment.

Action taken by the Minnesota Department of Health:

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36744	A. BUILDING: _____ B. WING _____	C 06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BEATITUDES HOMES LLC	3812 COMMODORE DRIVE BROOKLYN CENTER, MN 55429

(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****** HOME CARE PROVIDER/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: #HL367449746C #HL367441963M On June 27, 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 four residents receiving services under the provider's Assisted Living license. The following correction orders are issued for #HL367449746C/#HL367441963M, tag identification 2890 and 2560.	0 000		
02290 SS=F	144G.91 Subd. 2 Legislative intent The rights established under this section for the benefit of residents do not limit any other rights available under law. No facility may request or require that any resident waive any of these rights	02290		

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02290	Continued From page 1 at any time for any reason, including as a condition of admission to the facility. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to respect the autonomy for four of four residents (R1, R2, R3, R4) reviewed when they developed and enforced house rules that restricted the resident's right to have food, drink, and alcohol in their rooms, perform random drug searches without the resident's approval, purchase lottery tickets, house curfew at 10:00 p.m., restricting visiting times, cleaning common areas, and restricting the volume on their televisions and radios. In addition, the licensee's house rules indicated the residents would be immediately discharged if they violated some rules. The licensee's policy and practice had the ability to effect all residents and their rights. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1's record was reviewed. R1 was admitted to the facility on August 10, 2023. R1's diagnoses included quadriplegia (paralysis of all four limbs) and traumatic brain injury (TBI). R1 received assistance with all activities of daily living (ADL)'s, mobility, transfers, repositioning, housekeeping, transportation, meals, and medication	02290		

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02290	Continued From page 2 management. R1 required staff assistance of two for all transfers as well as some ADL's. R1 was unable to reposition or transfer himself and needed total staff assistance. R1 was alert and oriented to person, place, and time and was mostly non-verbal but understood what was being said and responded with yes or no questions. R1 was at risk to be abused. R2's record was reviewed. R2 was admitted to the licensee's facility on January 16, 2024. R2's diagnoses included intellectual disability, schizophrenia, suicidal ideation. R2 received assistance with personal care reminders, supervision with transfers, transportation, shopping, and medication management. R2 was at risk to be abused and required constant staff support. R3's record was reviewed. R3 was admitted to the facility on April 5, 2024. R3's diagnoses included end-stage chronic obstructive pulmonary disease (COPD) with chronic hypoxia respiratory failure. R3 was on hospice and received assistance with supplemental oxygen, continuous positive airway pressure (CPAP) machine, nebulizer reminders, personal cares, toileting, transfers with a one-person assist, medication management, and wheelchair mobility. R3 was at risk to be abused. R4's record was reviewed. R4 was admitted to the licensee's facility on August 27, 2020. R4's diagnoses included stroke. R4 received assistance with personal cares, meals, transfers with a one or two person assist, medication management, toileting, and wheelchair mobility. R4 was at risk to be abused. On June 27, 2024, at 10:05 a.m., the investigator	02290		

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02290	Continued From page 3 entered the facility. At 10:45 a.m., unlicensed personnel (ULP)-A brought the investigator downstairs to obtain R1's record to review. R1's record contained a copy of the licensee's house rules. The investigator reviewed the house rules. The licensee's document titled House Rules, updated September 9, 2023, listed 24 house rules the residents must abide by. The following house rules were more egregious: *House Rule #1: There is ABSOLUTELY NO FOOD/DRINKS IN THE ROOMS. ALL RESIDENTS ARE TO EAT IN DINING ROOM OR COMMON AREA. *House Rule #2: Absolutely NO alcohol will be permitted while you are a resident of THE BEATITUDES HOMES LLC. This always applies including while you are away from THE BEATITUDES HOMES LLC. Violations of this will result in immediate DISCHARGE. *House Rule #4: Residents are subject to random Drug and Alcohol testing at any time if the House Manager decides to test. Failure to these tests or refusal of these tests will result in immediate discharge from the Home. *House Rule #8: No SMOKING inside the Home. Doing so will result in immediate discharge. *House Rule #10: Gambling is strictly prohibited, including the purchase of lottery tickets. *House Rule #13: House curfew is 10:00 p.m. every night. The doors will be locked at that time unless approved by the House Manager. Any resident returning after 10:00 p.m. must find other sleeping arrangements for the night. THREE TIMES of late return to Home in same month will result in discharge. *House Rule #16: All residents will be responsible for keeping the common area cleaned. *House Rule #20: TV and Radio Volumes are to	02290		

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02290	Continued From page 4 be at a level not to be heard in the hallways. Headphones must be used after 11:00 p.m. *House Rule #23: The House Manager has the final decision as to whether a resident is following the rules and whether the resident can remain at the Home. Underneath the rules was the sentence, "RULES ARE SUBJECT TO CHANGE WITHOUT NOTICE." On June 27, 2024, at 11:55 a.m., owner (OW)-D stated the facility did not really follow the house rules stating residents come and go and have visitors all the time. OW-D stated the house rules were developed when the facility was a group home under the comprehensive home care license however, the policy was updated on August 8, 2023, following the conversion to the assisted living licensure. The licensee's policy titled Bill of Rights, dated October 11, 2021, indicated the licensee's staff would be trained on the concepts/rights contained in the Bill of Rights (BOR). TIME PERIOD TO CORRECT: Seven (7) days.	02290		
02560 SS=G	144G.92 Subdivision 1. Retaliation prohibited A facility or agent of a facility may not retaliate against a resident or employee if the resident, employee, or any person acting on behalf of the resident: (1) files a good faith complaint or grievance, makes a good faith inquiry, or asserts any right; (2) indicates a good faith intention to file a complaint or grievance, make an inquiry, or assert any right;	02560		

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02560	Continued From page 5 (3) files, in good faith, or indicates an intention to file a maltreatment report, whether mandatory or voluntary, under section 626.557; (4) seeks assistance from or reports a reasonable suspicion of a crime or systemic problems or concerns to the director or manager of the facility, the Office of Ombudsman for Long-Term Care, the Office of Ombudsman for Mental Health and Developmental Disabilities, a regulatory or other government agency, or a legal or advocacy organization; (5) advocates or seeks advocacy assistance for necessary or improved care or services or enforcement of rights under this section or other law; (6) takes or indicates an intention to take civil action; (7) participates or indicates an intention to participate in any investigation or administrative or judicial proceeding; (8) contracts or indicates an intention to contract to receive services from a service provider of the resident's choice other than the facility; or (9) places or indicates an intention to place a camera or electronic monitoring device in the resident's private space as provided under section 144.6502. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of four residents (R1) with records reviewed, was not retaliated against. The licensee threatened to not allow R1 to return to the facility after R1's family member (FM)-D questioned the licensee how R1 sustained unexplained injuries. In addition, during the on-site investigation of the unexplained injury, the licensee threatened to discharge R1 due to his care needs even though R1's service	02560		

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02560	Continued From page 6 requirements remained unchanged. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's record was reviewed. R1 was admitted to the licensee's facility on August 10, 2023. R1's diagnoses included quadriplegia (paralysis of all four limbs) and traumatic brain injury (TBI). R1's admission assessment dated August 10, 2023, indicated R1 had a gastrostomy (G)-tube (a tube inserted through the stomach for feeding and medication administration), and a suprapubic catheter (tubing inserted directly into the bladder to drain urine). R1 was totally dependent on staff due to his immobility and quadriplegia, required maximum assistance of two-staff at all times for transfers, a mechanical sling lift for transfers, and when being dressed and undressed. R1 responded to yes/no questions to make his needs known and was able to communicate a few words when prompted and given time. R1's progress note dated February 3, 2024, at 9:36 a.m., R1 was transported to the hospital after R1 complained of severe leg and hip pain for over 24 hours. R1's hospital record dated February 3, 2024, indicated R1 was diagnosed with an acute left	02560		

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02560	Continued From page 7 femoral hip fracture from a suspected fall from his mechanical sling (Hoyer) lift. R1 told hospital staff he fell from his Hoyer lift at the facility last week. R1 was able to mouth words, answer some questions, and demonstrate the ability to understand hospital doctors when asked how he fractured his hip and femur. In an email dated February 4, 2024, at 11:56 a.m., from family member (FM)-D to owner (OW)-E and case manager (CM)-C, FM-D indicated OW-E was "currently very upset," when hospital staff informed her R1 fractured the lower part of his hip and femur due to being dropped at the facility approximately a "WEEK" ago. FM-D raised concerns why the facility never contacted her after R1 was sent to the hospital or why the facility never filed an incident report. FM-D indicated, "this is unacceptable." In an email dated February 6, 2024, at 12:52 p.m., from OW-E to registered nurse (RN)-B, RN-F, CM-C, and FM-D, OW-E indicated she requested the hospital "hold" on R1's discharge back to the facility until she heard from CM-C and FM-D. OW-E indicated, "The email I received yesterday (from a family member) is not one I take lightly. Being accused of negligence is a serious alarming issue." R1's assessment dated June 10, 2024, indicated R1 still had a G-tube and suprapubic catheter. R1 was totally dependent on staff due to his immobility and quadriplegia and required maximum assistance of two-staff at all times for transfers, a mechanical sling lift, and being dressed and undressed. R1 responded to yes/no questions to make his needs known and was able to communicate a few words when prompted and given time.	02560		

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02560	Continued From page 8 R1's record lacked evidence his needs, services, and number of staff needed to provide his services increased since he was admitted to the licensee's facility. On June 27, 2024, at 10:05 a.m., the investigator entered the facility to initiate a complaint investigation regarding R1's unexplained fractures he sustained on or around February 3, 2024. On June 27, 2024, at 1:37 p.m., while the investigator was onsite at the facility, OW-E sent the following email to CM-C, "Please consider this email as a formal request to discharge R1 from the Beatitudes Homes. Currently, we cannot afford to provide two staff to R1 at this time. Beatitudes is unable to continue to adequately provide the services agreed to R1 in the assisted living contract." On July 1, 2024, at 2:00 p.m., FM-D stated an emergency medical technicians (EMT) told her R1 sustained the hip fracture due to being dropped. FM-D stated she sent an email to OW-E wanting an explanation how R1 sustained his injuries and why the facility never contacted her. FM-D stated OW-E was angry at CM-C and FM-D for accusing the facility of dropping R1. FM-D stated, "EMT told me he was dropped, so I didn't feel like I was accusing anyone." FM-D stated OW-E was "very defensive" and insisted facility staff did not drop R1. FM-D stated the emails and conversations between she and OW-E occurred during the time the hospital was getting ready to discharge R1 back to the facility, stating OW-E said R1 would not be allowed to return to the facility if "this was how it was going to be." FM-D stated she then apologized to OW-E	02560		

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02560	Continued From page 9 even though OW-E never explained how R1 sustained his injuries. FM-D stated CM-C received R1's discharge notice before she did, stating CM-C questioned OW-E about the timing of R1's June 27, 2024 discharge notice being sent the same day as the investigator's onsite visit to the facility but stated OW-E denied the timing had anything to do with investigator's onsite visit. On July 2, 2024, at 10:00 a.m., OW-E stated R1's discharge was "about to happen" before the investigator walked through the door. OW-E stated "we just cannot afford the staffing ratio for R1. It's taken a toll on us." The licensee's policy titled Retaliation is Prohibited at The Beatitudes Homes, dated October 11, 2021, indicated a facility, or agent of the facility may not retaliate against a resident or employee if the resident, employee, or any person acting on behalf of the resident if they file a good faith complaint or grievance, makes a good faith inquiry, or asserts any right. Retaliation against a resident includes but was not limited to any of the following actions taken or threatened by a facility or an agent of the facility against a resident, or any person with familial, personal, legal, or professional relationship with the resident: Termination of a contract or restriction of any rights granted to residents under state or federal law. TIME PERIOD FOR CORRECTION: Seven (7) days.	02560		