Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL367442842M
Compliance #: HL367444645C

Date Concluded: June 22, 2023

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: Kris Detsch, 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 alleged perpetrators (AP 1, AP 2, AP 3, AP 4, AP 5) emotionally abused a resident when they made threatening statements to her which resulted in her feeling depressed and suicidal.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was not substantiated. Although, the resident reported incidents occurred with AP 1, AP 2 and AP 3, there was not a preponderance of evidence to support the allegations occurred as reported. There were no witnesses to the allegations, no reports to law enforcement for verbal or physical altercation, no reports to the facility management and therefore no incident reports.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement and case workers. The investigation included review of resident's medical records, employee files, and

facility policies. Also, the investigator toured the facility and observed staff interactions with residents.

The resident resided in an assisted living facility. The resident's diagnoses included obsessive compulsive disorder (OCD), suicidal thoughts, bipolar disorder, attention-deficit/hyperactivity disorder (ADHD), anxiety, depression, and diabetes. The resident's service plan included assistance with medication administration, behavior management, meals, laundry, and housekeeping. The resident's care plan indicated she required reminders for dressing and grooming. The resident walked independently. The resident was verbally and physically aggressive. The resident was non-compliant with medication management.

During an interview, the resident said she lived at the facility because she needed assistance to get back into the community. The resident said there were three incidents she wanted to report. The resident said she cursed a lot to help her let out her anger. The first incident, the resident said she cussed, and AP 1 told her to, "watch her language" and a verbal altercation occurred between the two of them. The resident said she cussed out AP 1, then AP 1 told her, "I will beat your ass, stop having an attitude and yelling at me." The resident said AP 1 did not hit or touch her and this was the first time AP 1 made any comments like that to her. The resident was unable to remember AP 1's name, but said, "she is usually really cool." The resident was unable to remember when this event occurred.

The second incident, the resident said she had an altercation with AP 2 about cooking. The resident said she threatened to harm herself. The resident said AP 2 told her to go ahead and kill herself. The resident said she went downstairs, got a razor blade, and planned on cutting her wrists. The resident said AP 2 went downstairs to check on her and another verbal altercation occurred. The resident said AP 2 pushed her, so she pushed her back and then proceeded to beat on AP 2's head. The resident said there were no other incidents with AP 2 before this incident and AP 2 did not return to the facility for approximately five months after the incident. The resident said when AP 2 returned, another altercation occurred between the two of them. The resident said AP 2 was outside, in her car, on a phone call, when the resident went to AP 2 to tell her another resident needed help. The resident said AP 2 pushed her away from the car. The resident said AP 2 helped the other resident, then brushed her shoulder up against her. The resident said she took AP 2 by the shirt and pulled her down to the ground. The resident said AP 2 pushed her with her shoulder because she was being "snooty." The resident said AP 2 did not hit her. The resident was unable to remember when this incident occurred.

The third incident, the resident said she had an altercation with AP 3. The resident said AP 3 bent over and used a dustpan for cleaning. The resident said she bumped into AP 3 while she was bent over, but it was an accident. The resident said AP 3 got up and pushed her. The resident said AP 3 pushed her from behind. The resident said she cursed at AP 3 then went to her room, slammed her door, and turned up her television obnoxiously loud. The resident said AP 3 did not hit her. The resident was unable to remember when this event occurred.

AP 1 was unknown. AP 2 and AP 3 declined the interview.

The resident did not indicate AP 4 and AP 5 were alleged perpetrators of maltreatment.

During an interview, a nurse said the resident required medication to manage her mood, psychotic behavior, and diabetes. The nurse said the resident often refused her medications. The nurse said she had multiple conversations with the resident's physicians to discuss the resident's medical condition. The nurse said she coordinated multiple appointments for the resident, however the resident refused to see her physicians. The nurse said she reported the resident's behaviors and self-neglect to authorities. The nurse said the resident's mood changed frequently, and law enforcement was involved with any physical altercations. The nurse said the resident called and texted her frequently about various things, but the resident did not tell her any staff member hit, pushed, or made threatening comments.

The resident's medication administration record (eMAR) indicated the resident refused her anti-psychotic, depression, and diabetic medications twenty-four times out of thirty-one days during the time frame of the alleged incidences.

Facility incident reports lacked evidence of these allegations.

Law enforcement had no record of any calls placed to the facility during the time frame of the alleged incidences.

In conclusion, the Minnesota Department of Health determined abuse 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.

Abuse: Minnesota Statutes section 626.5572, subdivision 2
"Abuse" means:
(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;
(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening;

Vulnerable Adult interviewed: Yes.
Family/Responsible Party interviewed: Not Applicable.
Alleged Perpetrator interviewed: AP 1 No, unknown. AP 2 and 3 declined interviews.

Action taken by facility:
The facility contacted the resident's medical providers and implemented their orders for care.

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
Or call 651-201-4890 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

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

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 05/23/2023

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 ASSISTED LIVING PROVIDER LICENSING 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: #HL367444645C/#HL367442842M On May 23, 2023, 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 order is issued for #HL367444645C/#HL367442842M tag identification 470.	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 License Providers. 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 surveyors' 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 subd. 1, 2, and 3.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that:	0 470		

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0 470	Continued From page 1 (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the staffing plan was developed and posted as required, including requiring identified awake staff 24hrs a day, seven days a week, potentially affecting all the licensee's current residents, staff, and visitors. 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	0 470		

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0 470	Continued From page 2 cause serious injury, impairment, or death), and is 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 included: On May 23, 2023, at 9:43 a.m., surveyor toured facility and observed a white board on a wall in the living room area with written staff names and a column for "in", "out". The white board had "live in" next to the name of two staff members. Surveyor observed a calendar in the same area with the days of the week and dates identified. The calendar had a horizontal column for 7:00 a.m. to 3:00 p.m. One staff was listed under Monday, no other staff listed for the rest of the days that week. The next column listed "Live-in", and a staff member was listed for Monday through Friday, and another staff listed for Saturday and Sunday. On May 23, 2023, at 9:43 a.m., unlicensed personnel (ULP)-J said she sleeps on the couch at night. ULP-J said live in staff work 16 hours and sleep on the couch. ULP-J said weekend staff start work at 12:00 a.m., and work until 3:00 p.m. ULP-J acknowledged the posted schedule and white board lacked 24-hour awake staff coverage, then said she sleeps only when another staff was present. On May 23, 2023, at 10:12 a.m., owner (OW)-A emailed surveyor a daily schedule. The schedule was like the posted schedule; however, OW-A added more names into the to 7:00 a.m. to 3:00 p.m. slots. The schedule indicated staff worked greater than 24 hours.	0 470		

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0 470	Continued From page 3 On May 23, 2023, at 1:25 a.m., OW-A acknowledged staffing schedule should be posted in complete. OW-A acknowledged staff should be awake. Licensee's policy titled Staffing and Scheduling, dated October 11, 2022, indicated a supervisor would develop a staffing plan to meet the residents' needs 24-hours a day, seven days a week. The staffing schedule would be posted in a central location and accessible to staff, residents, volunteers, and the public. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		