Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL395224362M
Compliance #: HL395225341C

Date Concluded: September 10, 2024

Name, Address, and County of Licensee Investigated:
Kind Way Homes
4213 83rd Avenue North
Brooklyn Park MN, 55443
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Kris Detsch, 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 facility failed to provide supervision and health care for a resident when he asked for assistance. As a result, law enforcement responded to the resident and determined he had high blood pressure.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The resident called law enforcement to report concerns about the facility and his care. Although law enforcement found the unlicensed personnel (ULP) sleeping and did not provide care, facility directed staff not to assist residents during the night. The facility admitted the resident into side B of a duplex home, which was only inspected and authorized by Minnesota Department of Health (MDH) to provide services in side A. The facility failed to provide the resident required services, medication assistance and address safety concerns.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted case workers, the resident's probation officer and law enforcement. The investigation included review of resident records, police reports, case worker notes and clinic records. Also, the investigator toured the facility and observed the duplex housing structure and the operational system of the facility.

The facility was a duplex structure home with two separate living areas. The Minnesota department of Health (MDH) inspected one side of the structure for licensure (side A). The facility reported side B would not be utilized to avoid additional physical environment requirements if they increased capacity size utilizing that side of the duplex. The facility staff were located in side A.

During an interview, the facility owner indicated he had known the resident from a previous facility he had worked at. The owner stated the resident did not like to "see" other people, so he moved him into side B of the duplex.

During an interview, the licensed assisted living director (LALD) stated the facility was "under pressure" to admit a resident before expiration of their provisional assisted living license. The LALD stated the facility team reviewed the resident's needs and felt they could meet his needs. The LALD stated the resident did not want to share space with anyone, therefore the moved him into side B.

At the time of the resident's admission, he was the first and only resident receiving services from the facility. The resident's diagnoses included high blood pressure, and schizophrenia. The resident's service plan included assistance with meals and 24 hour/7 day a week health aide service but lacked further identification of the services the resident required staff to provide.

The facility received an assessment from the county which identified the resident's medical history. Then, the facility assessed the resident and identified the services the resident required and the services they would provide for him. The facility submitted the county waiver form to receive payment for the services.

The county waiver indicated the services the facility would provide included providing meals, assistance with dressing, grooming, bathing, and walking, assistance with medications, monitoring his blood pressure and assistance with managing behaviors.

SERVICES

The resident's care plan indicated the resident was independent with mobility, dressing, grooming, bathing, and walking. The care plan directed staff would help the resident prepare meals "when needed."

The facility lacked a service record the first month the resident admitted. The second month, the resident's service record indicated he was provided breakfast one day and all of the meals

on another day out the 18 days of the month he was at the facility. The service record also indicated he received housekeeping services one day out of the 18 days and the record lacked any indication other services were provided including bathing reminders and behavior monitoring.

Law enforcement records indicated late in the night, the resident called them for assistance because his air conditioner was not working, and he did not have running hot water. Initially, when officers arrived, first responders informed them the resident had, “very high blood pressure.” The resident stated the staff were “next door,” but they do not come to side B. Officers attempted to alert the ULP, who was on side A, however she did not respond when they rang the doorbell or when they knocked on the door. When officers looked through the window, they observed the ULP sleeping. The ULP told officers the resident came over to side A because of a “medical issue,” she called the nurse, but was unable to get ahold of her. She then told the resident to go back to his room on side B. The ULP informed the officers a manager told her they are not to assist the residents after a certain time during the night. The officers directed the ULP to take the resident’s blood pressure because she was his caregiver. The resident declined going to the hospital.

During an interview, the case manager said she provided the facility an assessment of the resident’s needs. After the case manager gave the assessment to the facility, the facility evaluated their capabilities to provide services for him and completed a document identifying what services they would provide, and the hours required to provide them. Based on this information, the facility received payment for providing the services. The case manager said the facility told the resident he could live on side B and staff would be on side A. The case manager said she received a voice mail from the resident on days three and four after admission stating he did not have pots, pans, or a can opener in the home. The next day the resident said the owner gave him money to buy his own groceries, pots, pans, and a toaster. The day after, during a meeting at the facility, the owner said one of the staff would bring the resident to the store to buy those items, but when the case manager talked to the resident the next day, he said this did not happen.

During an interview with the registered nurse (RN), she stated the resident was independent with his activities of daily living and wanted to do his own laundry. The RN stated ULP reported the resident refused help. Regarding food, the resident told her he cooked or went out to eat and if he needed help, he said he would ask staff members. The RN said she did not see anybody make food for him. The RN said if the resident required help, he would have to go to the other side of the duplex and ask a staff member. The RN stated the facility did not have a call system and she was unsure if the resident had a phone to use.

During an interview, the owner stated he assumed the ULP was not sleeping during the night because she knocked on the door to do a safety check and she called him to report the resident had called law enforcement.

The ULP declined the interview.

MEDICATION SERVICES

The county waiver assessment, completed by the facility, indicated the resident required assistance with "self-administration" of medications because he would forget to take some or all of them. The assessment indicated the resident's mental health impeded his ability to manage his medications. The assessment indicated staff would prepare the prescribed medications, document the medication administration, and report any concerns to the nurse. The assessment indicated the nurse would review the provider's orders for accuracy and set up the resident's medications. Staff would remind the resident to take his medications at 7:00 a.m., 7:30 a.m., 8:00 a.m., 8:30 a.m., and 9:00 a.m. The assessment indicated he demonstrated noncompliance in adhering to his prescribed medication regimen, thereby increasing the potential for severe health risks.

The resident's nursing assessment completed upon his admission to the facility indicated he had high blood pressure, depression, and delusions. The resident did not take anti-psychotic medication (used to treat psychosis). The resident had verbal aggression and angry outbursts. This assessment failed to identify medications the resident required, but indicated he could "safely" self-administer them. The assessment indicated the resident told the nurse he took his medications independently and he would get a physician's order stating he could "self-administer" them. The assessment indicated the resident's blood pressure upon admission to the facility was 170/101 (normal blood pressure 120/60). The nursing assessment completed fifteen days after admission indicated the resident's blood pressure was 151/85. This nursing assessment indicated the resident did not answer his door when the nurse knocked on it, then later came out of his room yelling and cussing at the nurse. The assessment indicated his vital signs (blood pressure) were within normal limits.

The resident's medication management plan indicated the resident required medication reminders from staff and assistance to self-administer those medications. The document indicated the resident was independent with storage and administration of his medications, although the document also indicated the nursing staff and ULP would supervise the resident's medications. This document lacked any identification of what medications the resident took.

The resident record lacked any record of physician orders, lacked a medication administration record or any other records to indicated staff provided the resident medications.

The investigator obtained a copy of the resident's medication from his primary care provider. The provider had seen the resident approximately one month prior to his admission. The resident's medication orders included daily scheduled medications for high blood pressure, high cholesterol, urine retention and an inhaler to be used as needed for shortness of breath.

During an interview, the resident's probation officer stated one of the court requirements for probation was for the resident to take his prescribed medications and to obtain a mental health

evaluation. The probation officer stated the facility was aware of the terms of the resident's probation and the owner worked with the resident prior to his admission to the facility.

During an interview, the RN stated she completed the resident's assessments. The RN stated the resident told her he wanted to administer his own medications, so she directed him to get a letter from his physician indicating he was capable to self-administer. The RN stated she did not observe any documentation in the resident's record from the resident's provider and did not know what medications he required. The RN stated the resident did not attend any medical appointments and she did not contact the resident's provider.

SAFETY

The county waiver assessment, completed by the facility, indicated the resident had multiple mental health diagnoses and his behaviors included anxiety, agitation, and verbal/physical aggression. The resident had a history of property destruction including starting fires and the facility would closely monitor him. He required close supervision when using the stove or oven. Additionally, the resident had a history of smoking inside the home which significantly increased the risk of a fire. He had a history of polysubstance abuse, an ongoing struggle with substance use and a pattern of engagement with the criminal justice system.

The resident's assessment indicated the resident was independent with smoking and inaccurately indicated he had no history of smoking concerns and no history of property damage due to smoking. The nursing assessment indicated the resident did not use drugs or alcohol. The nursing assessment indicated the resident had verbal aggression and angry outbursts.

The resident's individual abuse prevention plan (IAPP) indicated interventions to manage the resident's behaviors included attending regular physician follow up visits and medications. The IAPP inaccurately indicated the resident was not at risk for self-abuse and not at risk to abuse others. The IAPP had no interventions listed and failed to indicate the resident was on parole for violence (assault and terroristic threats). The IAPP lacked information regarding the resident's history of substance abuse, alcohol abuse, and property destruction. The IAPP lacked interventions regarding the resident's delusions or paranoia. The resident's IAPP lacked indication he received services from a probation officer and lacked terms of his probation.

The resident's care plan listed the goals of his care was to minimize the occurrence and intensity of manic and depressing episodes. Another goal was for the resident to strive for consistency in mood to reduce the disruptive impact on daily life. The care plan lacked interventions or direction to ULP on what actions they should take to minimize the occurrence and intensity of manic and depressive episodes.

An incident report indicated the ULP heard the resident banging on the door. When she opened the door, she observed the resident standing there with a knife. The resident said the knife was for his protection. The report indicated the resident accused staff members of lying and became

angry and verbally aggressive. The report also indicated the facility did not notify the resident's physician or mental health providers of the incident.

The RN assessed the resident the next day. The assessment indicated the resident initially did not answer the door, then came out "yelling" and "cussing" because he missed a medical appointment. The assessment lacked inventions or care provided for behavior management.

During an interview, the case manager said approximately a week after admission, she attended a meeting with the resident and facility staff. At this meeting the staff agreed to provide safety checks to the resident a minimum of twice daily. The case manager said she never received any "proof" staff checked on him twice daily. The case manager said she received multiple messages from the resident about various issues and he called emergency services (911) multiple times. The case manager the resident lived alone on side B at the facility for approximately one month then she helped him move to a crisis center location.

During an interview, the LALD stated the team was aware the resident had high behaviors and was extremely difficult to work with. The LALD stated during the knife incident nobody was hurt and the ULP asked the resident to give the knife to them, but the resident did not comply.

During an interview, the RN said she was not involved in the admission process until after the resident admitted to the facility. The RN stated the facility was new and they were still working things out.

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.

Mitigating Factors considered, Minnesota Statutes, section 626.557, Subd. 9c(f):

(1) The facility did not follow an erroneous order, direction or care plan with awareness and failure to take action.

The facility did direct an erroneous order, direction, or care plan.

(2) The facility was not in compliance with regulatory standards.

The facility failed to provide proper training and/or supervision of staff.

The facility provided adequate staffing levels.

(3) The facility failed to follow professional standards and/or exercise professional judgement.

The facility failed to act in good faith interest of the vulnerable adult.

The maltreatment was not a sudden or foreseen event.

Vulnerable Adult interviewed: No. Attempted.
Family/Responsible Party interviewed: No. Attempted.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility worked with the resident's case manager.

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
Hennepin County Attorney
Brooklyn Park City Attorney
Brooklyn Park Police Department
Minnesota Board of Nursing
Minnesota Board of Executives for Long Term Services and Supports
MN Department of Human Services, Office of Inspector General, Surveillance Integrity Review Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39522	A. BUILDING: _____ B. WING _____	C 07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KIND WAY HOMES	4213 83RD AVE N BROOKLYN PARK, MN 55443

(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: HL395225341C/HL395224362M On July 25, 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 was one resident receiving services under the provider's provisional Assisted Living license. The following correction orders are issued for HL395225341C/HL395224362M, tag identification 250, 330, 460, 470, 485, 630, 690, 1640, 1650, 1730, 2360.	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 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.	
0 250 SS=G	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a	0 250		

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0 250	Continued From page 1 provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter;	0 250		

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0 250	Continued From page 2 (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the management officials who were in charge of the day-to-day operations; and responsible for the resident's assisted living services, understood all of the assisted living facility regulations. The licensee failed to admit one of one residents (R1) into safe dwelling space, failed to provide minimum requirements and failed to provide required services for R1. 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:	0 250		

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0 250	Continued From page 3 The licensee submitted an application dated September 9, 2022, indicating the licensee was applying for a provisional assisted living facility (PALF) license, indicating the type was for a single building with 2 or more addresses on the same property. The application indicated capacity was four residents and the physical address of the facility was house number 4209 with the business mailing address at house number 4213. On October 31, 2022, email correspondence from the licensee to Minnesota Department of Health (MDH) indicated the licensee was leasing one side of the duplex 4209. On January 4, 2023, MDH communication indicated the licensee acquired lease of both sides of the duplex (4209 and 4213) and requested to increase the capacity of their initial application from four residents to eight. An invoice dated January 5, 2022, was provided to the licensee for the cost of increasing resident capacity eight. On February 1, 2023, MDH communication indicated the licensee was communicated the additional physical environment regulations on a capacity size six or more residents. On February 22, 2023, email correspondence from the licensee to MDH indicated the capacity requirements were more than they were ready for and only wanted to pursue with the PALF application for address 4213. The licensee submitted an updated PALF application with 4213 being the physical location of the facility and capacity size of four. The licensee changed their mind about licensing both sides of the dwelling and only wanted to	0 250		

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0 250	Continued From page 4 pursue with the PALF application for address 4213. The licensee submitted an updated PALF application with 4213 being the physical location of the facility and capacity size of four. On March 14, 2023, at 9:18 a.m., MDH sent licensed assisted living director (LALD)-D an email indicating there were outstanding items that needed to be addressed. One of them was the separate building requirement. Due to the MDH licensing policy, a two-hour rated property separation firewall was required between the adjoining units. On August 3, 2023 at 7:53 p.m., the licensee provided email communication to MDH with an attachment of an updated floor plan of 4213 with an exit to the back of the house. The licensee indicated 4209 would remain vacant until further notice. Engineering inspection notice clearance form dated August 8, 2023, indicated the facility was reviewed and inspected for four residents' capacity in the 4213 side only, and the 4209 side was vacant. The licensee was issued a PALF licensee effective on August 11, 2023 and the expiration date was August 10, 2024. The address listed on licensure was 4213. On June 11, 2024, the licensee submitted notice of providing assisted living services document to MDH. The document indicated the licensee provided services to one resident (R1). On July 25, 2024, at 5:15 a.m., the surveyor entered the licensee's building [4213]. Unlicensed personnel (ULP)-F stated R1 left and did not	0 250		

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0 250	Continued From page 5 know where he went. ULP-F stated R1 lived in the other side (house number 4209). ULP-F stated he could not get into that side of the duplex because it was locked up by R1. The surveyor observed one resident, (R2), located at 4213. ULP-F stated there were no resident's living in the basement of the home. R1 admitted to the licensee on June 11, 2024. R1's diagnoses included schizophrenia, post-traumatic stress disorder (PTSD), and antisocial personality disorder. R1's assisted living contract dated June 11, 2024, indicated the agreement describes the terms in with the licensee would provide R1 with housing and services at "4213/4209" address, with the licensee, Kindway Home Services, LLC PALF license. On July 30, 2024, at 2:23 p.m., owner (OW)-C said he knew R1 from a facility he previously worked at, but R1 left that facility and went to a different facility. OW-C said R1 called him and asked if he could move into one of his facilities because R1's current facility evicted him. OW-C said R1 did not like to "see" other people, so he moved him into the side of the duplex home [4209], opposite of staff members. On July 31, 2024, at 2:33 p.m., LALD-D said he was involved in admitting R1 into the facility. LALD-D said the licensee was under pressure to receive a resident to meet licensure requirements. LALD-D acknowledged R1's services but said most of the time he only wanted reminders and did not want people doing things for him. LALD-D said the licensee had a "team" meeting about R1's needs and the team thought they could meet his needs. LALD-D said the licensee completed the "6790 document" and	0 250		

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0 250	Continued From page 6 submitted it to R1's case manager who agreed with admission. LALD-D said R1 was amicable and agreeable upon admission. LALD-D said the licensee admitted R1 into the duplex side of the home (not licensed) because of his behaviors, and R1 did not want to share space with anybody. The licensee failed to provide minimum requirements and required services to R1 evident in the issuance of tags 330, 460, 470, 485, 630, 690, 1640, 1650, 1730, and 2360. Time period for correction: Seven (7) days.	0 250		
0 330 SS=D	144G.30 Subd. 4 Information provided by facility (a) The assisted living facility shall provide accurate and truthful information to the department during a survey, investigation, or other licensing activities. (b) Upon request of a surveyor, assisted living facilities shall within a reasonable period of time provide a list of current and past residents and their legal representatives and designated representatives that includes addresses and telephone numbers and any other information requested about the services to residents. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee provided surveyor altered documentation for one of one resident (R1) with records reviewed. 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	0 330		

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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
0 330	Continued From page 7 cause 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 admitted to the licensee on June 11, 2024. R1's diagnoses included schizophrenia, post-traumatic stress disorder (PTSD), and antisocial personality disorder. On July 25, 2024, at 5:15 a.m., the surveyor entered the licensee's building. The surveyor observed a "binder" which contained hand-written documentation. Unlicensed personnel (ULP)-F said staff members write information regarding the resident on the sheets, in the book. The surveyor observed the book and took photos of the documentation within the book. On July 31, 2024, at 4:06 p.m., the surveyor sent an email request to licensed assisted living director (LALD)-D and owner (OW)-C requesting further documentation regarding R1. The document request included ULP's documentation notes from June 2024 through July 2024. On August 7, 2024, at 2:08 p.m., the surveyor received an email from the licensee that contained ULP documentation. Documentation provided included documented notes altered from its original state when compared to the photos of the same documents the surveyor took while on site. Documentation appeared to have been altered (added). Example as follows: -Photo taken of documentation on June 30, 2024	0 330		

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	39522	A. BUILDING: _____ B. WING _____	C 07/25/2024

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0 330	Continued From page 8 lacked documentation from 7:00 a.m. to 3:00 p.m. The top page was blank, lacked documentation notes. Documentation the licensee provided the surveyor included a note on the top page which was previously blank. The documentation also included a name after each entry (not present previously). -Photo taken of documentation on July 10, 2024, lacked documentation on the bottom of the page from 3:00 p.m. to 11:00 p.m.. Documentation the licensee provided the surveyor included a note on the bottom of the page which was previously blank. The documentation also included a name after each entry (not present previously). Time period for correction: Seven (7) days.	0 330		
0 460 SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit;	0 460		

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0 460	Continued From page 9 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a means to summon staff for assistance for two of two residents (R1, R2) with record reviewed. 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) 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: The licensee Uniform Disclosure of Assisted Living Services and Ammenities (UDALSA) dated January 12, 2023, indicated unlicensed personnel (ULP) would be in the building and available to resident requests 24/7 (24 hours per day, seven days a week) and had a call light or bell system to summon staff. R1 admitted to the licensee on June 11, 2024. R1's diagnoses included schizophrenia, post-traumatic stress disorder (PTSD), and antisocial personality disorder. R1's assisted living contract dated June 11, 2024, indicated the agreement describes the terms in with the licensee would provide R1 with housing and services at "4213/4209" address, with the licensee, Kindway Home Services, LLC PALF license. R1's customized living rates worksheet (commonly known as 6790) dated June 4, 2024,	0 460		

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0 460	Continued From page 10 was written by the licensee, and submitted to case manager (CM)-A for payment of services. The 6790 form indicated R1 had anxiety, agitation, and verbal/ physical aggression. The 6790 form indicated R1 had a history of property destruction including starting fires. The licensee indicated R1 required close supervision when using the stove or oven. Additionally, R1 had a history of smoking inside the home which significantly increased the risk of a fire. The 6790 form indicated R1 had a history of polysubstance abuse and an ongoing struggle with substance use and a pattern of engagement with the criminal justice system. The form indicated services R1 received would include: -assistance with dressing, grooming, bathing, positioning, and walking -assistance with self-administration of medications -verbal and visual medication reminders -other delegated task: elevated blood pressure -medication set ups and monitoring -managing orientation issues -managing anxiety -managing agitation -manage verbal aggression -manage physical aggression -manage property destruction -meet other cognitive/mental health need: managing schizoaffective, bipolar type, chronic PTSD, and polysubstance abuse R2's diagnoses included bipolar, severe anxiety and asthma. R2's care plan dated July 10, 2024, indicated R2 required supervision for falls and medication assistance. On July 30, 2024, at 9:25 a.m., registered nurse (RN)-B said if R1 required help, he would have to go to the other side of the duplex and ask staff	0 460		

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0 460	Continued From page 11 member. RN-B said he had "free will". RN-B was unsure if he had a phone, but there was a phone in the home where the staff members reside. RN-B said the licensee did not have a "call system" (call pendant). TIME PERIOD TO CORRECT: Seven (7) days.	0 460		
0 470 SS=D	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (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;	0 470		

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0 470	Continued From page 12 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure staff members were awake 24 hours per day for one of one resident (R1) with record reviewed. The licensee admitted R1 into the side of the duplex home, opposite from staff members, to live alone. 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) 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: The licensee Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) dated January 12, 2023, indicated unlicensed personnel (ULP) would be in the building and available to resident requests 24/7 (24 hours per day, seven days a week). The UDALSA indicated services included the licensee prepared to manage challenging behaviors with one to one staff available, and provide safety checks up to every 15 minute. R1 admitted to the licensee on June 11, 2024. R1's diagnoses included schizophrenia, post-traumatic stress disorder (PTSD), and antisocial personality disorder. R1's assisted living contract dated June 11, 2024, indicated the agreement describes the terms in with the licensee would provide R1 with housing and services at "4213/4209" address, with the licensee, Kindway Home Services, LLC PALF	0 470		

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0 470	Continued From page 13 license. R1's customized living rates worksheet (commonly known as 6790) dated June 4, 2024, was written by the licensee, and submitted to case manager (CM)-A for payment of services. The 6790 form indicated R1 had anxiety, agitation, and verbal/ physical aggression. The 6790 form indicated R1 had a history of property destruction including starting fires. The licensee indicated R1 required close supervision when using the stove or oven. Additionally, R1 had a history of smoking inside the home which significantly increased the risk of a fire. The 6790 form indicated R1 had a history of polysubstance abuse and an ongoing struggle with substance use and a pattern of engagement with the criminal justice system. The form indicated the services R1 would received included: -assistance with dressing, grooming, bathing, positioning, and walking -assistance with self-administration of medications -verbal and visual medication reminders -other delegated task: elevated blood pressure -medication set ups and monitoring -managing orientation issues -managing anxiety -managing agitation -manage verbal aggression -manage physical aggression -manage property destruction -meet other cognitive/mental health need: managing schizoaffective, bipolar type, chronic PTSD, and polysubstance abuse Law enforcement records dated June 26, 2024, at 1:44 a.m., indicated officers arrived to the 4209 unit. R1 called them because his air conditioning was not functioning, and he had no hot water. R1	0 470		

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0 470	Continued From page 14 stated there are staff "next door" but they do not come by. The records indicated officers went to the 4213 unit, knocked and rang the doorbell several times, however no staff member (ULP) responded. Law enforcement looked through a window and observed an ULP sleeping. The ULP told law enforcement R1 came over several times and complained of a medical issue, so she called the nurse line, and no one answered. She then told R1 to go back to his room. The ULP informed the officers a manager told her they are not to assist the residents after a certain time during the night and she did not assist him with what he needed. R1 complained his blood pressure was high and during law enforcement response, the ULP went to unit 4209 to take R1's blood pressure. On July 29, 2024, at 1:33 p.m., CM-A said she provided the licensee the county assessment. This was an assessment based on what R1 required for care and services. The licensee reviewed the assessment, then provided the 6790 document. The licensee indicated they could provide care and services to R1 and moved him into their duplex style home. R1 lived on one side of the duplex alone. CM-A said there were multiple case notes and notes from R1 (almost every other day). CM-A said at the team meeting they discussed (and wrote out) an agreement indicating staff would have 24-hour access to the house, staff would knock before entering, safety checks through the day, a minimum of safety checks twice daily. CM-A said she never received proof staff checked on R1 a minimum of two times per day. CM-A said R1 indicated he was not getting assistance from the staff member. CM-A said R1 called law enforcement multiple times, and approximately one month later, CM-A helped R1 discharge from the licensee and admit into a	0 470		

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0 470	Continued From page 15 crisis center. On July 30, 2024, at 9:25 a.m., registered nurse (RN)-B said if R1 required help, he would have to go to the other side of the duplex and ask staff member. On July 30, 2024, at 2:23 p.m., owner (OW)-C said R1 did not like to "see" other people, so he moved him into the side of the duplex home opposite of staff members. OW-C said he assumed the ULP was not sleeping during the night because she knocked on R1's door to do a safety check and called and told him R1 called the police. The licensee policy titled, Service Plan, dated August 1, 2021, indicated the licensee would provide all the services required by the current service plan. TIME PERIOD TO CORRECT: Seven (7) days.	0 470		
0 485 SS=D	144G.41 Subdivision 1. (13)(i)(A)and(C) Minimum Requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (A) menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a	0 485		

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0 485	Continued From page 16 food that is served. Residents must be informed in advance of menu changes; and (C) the facility cannot require a resident to include and pay for meals in their contract; (ii) weekly housekeeping; (iii) weekly laundry service; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide three meals and snacks per day as required for one of one resident (R1) with record reviewed. The licensee admitted R1 into the side of the duplex home, opposite from staff members, to live alone. 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) 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: The licensee Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) dated January 12, 2023, indicated unlicensed personnel (ULP) would be in the building and available to resident requests 24/7 (24 hours per day, seven days a week) and required to provide three meals plus snacks. R1 admitted to the licensee on June 11, 2024. R1's diagnoses included schizophrenia, post-traumatic stress disorder (PTSD), and antisocial personality disorder. R1's assisted living contract dated June 11, 2024, indicated the	0 485		

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0 485	Continued From page 17 agreement describes the terms in with the licensee would provide R1 with housing and services at "4213/4209" address, with the licensee, Kindway Home Services, LLC PALF license. R1's customized living rates worksheet (commonly known as 6790) dated June 4, 2024, was written by the licensee, and submitted to case manager (CM)-A for payment of services. The 6790 form indicated R1 had anxiety, agitation, and verbal/ physical aggression. The 6790 form indicated R1 had a history of property destruction including starting fires. The licensee indicated R1 required close supervision when using the stove or oven. The form indicated the licensee would provide the following services preparation of breakfast, lunch, supper, and two snacks. On July 29, 2024, at 1:33 p.m., CM-A said she provided the licensee the county assessment. This was an assessment based on what R1 required for care and services. The licensee reviewed the assessment, then provided the 6790 document. The licensee indicated they could provide care and services to R1 and moved him into their duplex style home. R1 lived on one side of the duplex alone. CM-A said she received a voice mail from R1 on June 14, 2024, and June 15, 2024, stating he did not have pots, pans, or a can opener in the home. CM-A said she attended a meeting with facility staff members and R1 on June 17, 2024. The day before the meeting she spoke to R1 who told here there were only paper cups and paper plates at the home, the owner gave him money to buy his own groceries, pots, pans, and a toaster. At the meeting, the owner said one of the staff would bring R1 to the store to buy those items, but when CM-A talked to R1 the	0 485		

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0 485	Continued From page 18 next day, R1 said this did not happen. CM-A said there were multiple case notes and notes from R1 (almost every other day). CM-A said at the team meeting they discussed (and wrote out) an agreement indicating staff would have 24-hour access to the house. On July 30, 2024, at 9:25 a.m., registered nurse (RN)-B said she was not involved in R1 admission process to the licensee, but completed his initial nursing admission assessment. R1 said he was independent and could do his activities of daily living (ADLS) himself. Regarding food, R1 told her he cooked or went out to eat and if he needed help, he said he would ask staff members. RN-B said she did not see anybody make food for him. RN-B said if R1 required help, he would have to go to the other side of the duplex and ask staff member. TIME PERIOD TO CORRECT: Seven (7) days.	0 485		
0 630 SS=G	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced	0 630		

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0 630	Continued From page 19 by: Based on interview and record review, the licensee failed to identify individualized interventions to prevent self-harm, and harm to others, for a resident with a known history of violent behavior, alcohol and substance abuse, paranoia, and delusions for one of one (R1) resident with record reviewed. R1 was on parole for various crimes including assaults, and terroristic threats, placing R1 at risk for serious harm towards others and himself. 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 admitted to the licensee on June 11, 2024. R1's diagnoses included schizophrenia, post-traumatic stress disorder (PTSD), and antisocial personality disorder. R1's county assessment dated May 24, 2024, indicated R1 had a criminal background and served jail time for an incident involving a weapon (knife) and the courts assigned R1 a probation officer. The assessment indicated R1 was at risk for self-neglect due to a history of behaviors that pose a threat to himself and others, alcohol and/or drug use, impaired judgement, and inability to manage medications. The assessment indicated R1 had a history of mental health hospitalizations and suicidal ideation.	0 630		

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0 630	Continued From page 20 R1's customized living rates worksheet (commonly known as 6790) dated June 4, 2024, was written by the licensee, and submitted to case manager (CM)-A for payment of services. The 6790 form indicated R1's diagnoses included schizoaffective disorder, bipolar disorder, alcohol dependence, antisocial personality disorder, auditory hallucinations, cocaine dependence, and depression. The 6790 form indicated R1 had anxiety, agitation, and verbal/ physical aggression. The 6790 form indicated R1 had a history of property destruction including starting fires. The licensee indicated R1 required close supervision when using the stove or oven. Additionally, R1 had a history of smoking inside the home which significantly increased the risk of a fire. The 6790 form indicated R1 had a history of polysubstance abuse and an ongoing struggle with substance use and a pattern of engagement with the criminal justice system. R1's initial nursing assessment dated June 11, 2024, indicated he had depression, anxiety, bipolar disorder, schizophrenia, delusions, chronic obstructive pulmonary disease (COPD). The assessment indicated R1 was independent with smoking and inaccurately indicated he had no history of smoking concerns and no history of property damage due to smoking. The nursing assessment indicated R1 did not use drugs or alcohol. The nursing assessment indicated R1 had verbal aggression and angry outbursts. R1's individual abuse prevention plan (IAPP) dated June 11, 2024, indicated R1 had anxiety and depression. The intervention listed to manage those conditions included regular physician follow up visits, and medications. The IAPP indicated there were no concerns with R1	0 630		

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0 630	Continued From page 21 smoking, the licensee would encourage smoking cessation, but failed to include interventions related to his history of smoking and starting fires. The IAPP indicated R1 did not use alcohol or drugs and failed to indicate R1's history of drug and alcohol abuse with interventions to prevent reoccurrence. The IAPP indicated R1 was susceptible to abuse from others and staff were to monitor for signs or symptoms of abuse or neglect from others. The IAPP inaccurately indicated R1 was not at risk for self-abuse and not at risk to abuse others. The IAPP had no interventions listed and failed to indicate R1 was on parole for violence (assault and terroristic threats). The IAPP lacked information regarding R1's history of substance (cocaine) abuse, alcohol abuse, and property destruction. The IAPP lacked interventions regarding R1's delusions or paranoia. R1's IAPP lacked indication he received services from a probation officer, and lacked terms of his probation. R1's care plan dated June 11, 2024, listed R1's diagnoses of schizophrenia, hypertension, bipolar depression, and manic depression. The care plan listed the goals of his care as follows. "The client will aim to minimize the occurrence and intensity of manic and depressing episodes." Also, "The client will strive for consistency in mood to reduce the disruptive impact on daily life." The care plan lacked interventions or direction to unlicensed personnel (ULP) on what actions they should take to minimize the occurrence and intensity of manic and depressive episodes. An incident report dated June 25, 2024, at 1:45 a.m., indicated an ULP heard banging on the door and proceeded to open it. The ULP observed R1 standing in the dark with a knife. R1 told the ULP it was for his protection. The report	0 630		

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0 630	Continued From page 22 indicated R1 said staff lied about him, and he became verbally aggressive. The report indicated the ULP walked away to deescalate the situation. R1's nursing assessment dated June 26, 2024, indicated R1 did not answer his door upon arrival of the nurse, but then came out of his room "yelling" and "cussing". The assessment indicated R1 was angry because he missed a medical appointment. The assessment lacked interventions for behavior management. On July 29, 2024, at 1:33 p.m., case manager (CM)-A said the licensee indicated they could provide care and services to R1 and moved him into their duplex style home. R1 lived alone on one side of the duplex home. CM-A said the licensee told R1 he would live alone, and staff members would be on the other side of the duplex. CM-A said R1 also had a history of suicidal ideation, cocaine dependence, alcohol dependence, and drug abuse. CM-A said she had meetings with the licensee staff, and expectations for them to provide care/services to R1. CM-A said R1 called emergency services (911) multiple times and CM-A assisted in discharging R1 from the licensee to a crisis respite location. On July 30, 2024, at 9:25 a.m., registered nurse (RN)-B said she was not involved in R1's admission process until after R1 arrived. RN-B said the licensee was new, and still working things out. On July 30, 2024, at 2:23 p.m., owner (OW)-C said he knew R1 from a facility he previously worked at, but R1 left that facility and went to a different facility. OW-C said R1 called him and asked if he could move into one of his facilities because R1 the prior facility evicted him. OW-C	0 630		

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0 630	Continued From page 23 said R1 did not like to "see" other people, so he moved him into the side of the duplex home, opposite of staff members. On July 31, 2024, at 2:33 p.m., licensed assisted living director (LALD)-D said he was involved in admitting R1 into the facility. LALD-D said the licensee was under pressure to receive a resident to meet licensure requirements. LALD -D acknowledged R1's services but said most of the time he only wanted reminders and did not want people doing things for him. LALD-D said the "team" were all aware he had very high behaviors and extremely difficult to work with, but the team thought they could meet his needs. LALD-D said the licensee completed the 6790 document and submitted it to R1's case manager who agreed with admission. LALD-D said initially R1 was nice, but later became verbally aggressive, insulting, and created chaos. R1 called law enforcement multiple times. Regarding the incident on June 25, 2024, LALD-D said nobody was hurt. LALD-D could not remember if there were other incidences with R1 involving knives, and said staff members asked him to give it back to them, but he didn't. LALD-D said R1 left the facility on July 18, 2024. On August 15, 2024, at 10:23 a.m., surveyor sent LALD-D and OW-C an email requesting the licensee's policy regarding IAPP. Surveyor did not receive a response regarding the licensee's IAPP policy. The licensees policy titled, Comprehensive Nursing Assessment, dated August 1, 2021, indicated a registered nurse (RN) would complete a comprehensive nursing assessment would include a review of neurocognitive evaluations and diagnoses, history/diagnoses of mood	0 630		

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0 630	Continued From page 24 disorders, and evaluation of medication/non-medication treatment and interventions. The licensee Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) dated January 12, 2023, indicated unlicensed personnel (ULP) would be in the building and available to resident requests 24/7 (24 hours per day, seven days a week). The UDALSA indicated services included the licensee prepared to manage challenging behaviors, provide safety checks up to every 15 minutes, and provided one to one staff if needed. Time frame for correction: Seven (7) days.	0 630		
0 690 SS=F	144G.43 Subdivision 1 Resident record (a) Assisted living facilities must maintain records for each resident for whom it is providing services. Entries in the resident records must be current, legible, permanently recorded, dated, and authenticated with the name and title of the person making the entry. This MN Requirement is not met as evidenced by: Based on observation and record review, the licensee failed to ensure progress notes contained required content including the name and title of the person making an entry for one of one resident (R1) with records reviewed. The licensee provided names of staff who wrote progress notes after an onsite visit. This deficient practice had the potential to affect all residents and staff. This practice resulted in a level two violation (a	0 690		

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0 690	Continued From page 25 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 admitted to the licensee on June 11, 2024. R1's diagnoses included schizophrenia, post-traumatic stress disorder (PTSD), and antisocial personality disorder. On July 25, 2024, at 5:15 a.m., the surveyor entered the licensee's building. The surveyor observed a "binder" which contained hand-written documentation. Unlicensed personnel (ULP)-F said staff members write information regarding the resident on the sheets, in the book. The surveyor observed the book and took photos of the documentation within the book. On July 31, 2024, at 4:06 p.m., the surveyor sent an email request to LALD-D and OW-C requesting further documentation regarding R1. The document request included ULP documentation notes from June 2024 through July 2024. On August 7, 2024, at 2:08 p.m., the surveyor received a email from the licensee that contained ULP documentation. Documentation provided included documented notes altered from its original state when compared to the photos of the same documents the surveyor took while on site. Multiple documentation notes indicated the licensee added a name after documentation notes before sending the notes to the surveyor.	0 690		

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0 690	Continued From page 26 Examples as follows: -Photo taken of documentation on June 24, 2024, 7:00 a.m. to 3:00 p.m., lacked signature of ULP who wrote the note. Documentation the licensee provided surveyor included a name of the ULP. -Photo taken of documentation on June 25, 2024, 7:00 a.m. to 3:00 p.m., and 3:00 p.m. to 11:00 p.m., lacked signature of ULP's who wrote the notes. Documentation the licensee provided the surveyor included a name after each note. -Photo take on documentation on June 26, 2024, 7:00 a.m. to 3:00 p.m., and 3:00 p.m. to 11:00 p.m., lacked signature of ULP's who wrote the notes. Documentation the licensee provided the surveyor included a name after each note. Time period for correction: Seven (7) days	0 690		
01640 SS=G	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record,	01640		

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01640	Continued From page 27 including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan was implemented for one of one resident (R1) with records reviewed. The licensee failed to provide identified services to R1 including assistance activities of daily living (ADL's), medication management, meals, and safety checks. The licensee failed to provide required supervision/monitoring services essential to R1's safety of himself and other related to his history of violence and property destruction. 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 admitted to the licensee on June 11, 2024. R1's diagnoses included schizophrenia, post-traumatic stress disorder (PTSD), and antisocial personality disorder. R1's county assessment dated May 24, 2024, indicated R1 had a criminal background and served jail time for an incident involving a weapon (knife) and the courts assigned R1 a probation	01640		

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01640	Continued From page 28 officer. The assessment indicated R1 was at risk for self-neglect due to a history of behaviors that pose a threat to himself and others, alcohol and/or drug use, impaired judgement, and inability to manage medications. The assessment indicated R1 had a history of mental health hospitalizations and suicidal ideation. R1's customized living rates worksheet (commonly known as 6790) dated June 4, 2024, was written by the licensee, and submitted to case manager (CM)-A for payment of services. The 6790 form indicated R1's diagnoses included schizoaffective disorder, bipolar disorder, alcohol dependence, antisocial personality disorder, auditory hallucinations, cocaine dependence, and depression. The 6790 form indicated R1 had anxiety, agitation, and verbal/ physical aggression. The 6790 form indicated R1 had a history of property destruction including starting fires. The licensee indicated R1 required close supervision when using the stove or oven. Additionally, R1 had a history of smoking inside the home which significantly increased the risk of a fire. The 6790 form indicated R1 had a history of polysubstance abuse and an ongoing struggle with substance use and a pattern of engagement with the criminal justice system. The form indicated the licensee would provide the following services: -homemaking -shopping -assistance with making appointments -arranging non-medical transportation -breakfast, lunch, supper, and two snacks -socialization -assistance with dressing, grooming, bathing, positioning, and walking -assistance with self-administration of medications	01640		

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01640	Continued From page 29 -verbal and visual medication reminders -other delegated task: elevated blood pressure -medication set ups and monitoring -managing orientation issues -managing anxiety -managing agitation -manage verbal aggression -manage physical aggression -manage property destruction -meet other cognitive/mental health need: managing schizoaffective, bipolar type, chronic PTSD, and polysubstance abuse The 6790 included the time required for staff to complete the following services: -0.75 hours per day is assisting him with dressing. -0.2 hours per day in assisting him with grooming. -0.5 hours per day in assisting him with bathing. -1 hour per day in assisting him with positioning. -1 hour per day in assisting him with walking. -2 hours per day in assisting him with self-administration of medications. -1 hour per day in assisting him with verbal or visual medication reminders. -1 hour per day with other delegated tasks including blood pressure monitoring. -2 hours per day with setting up and monitoring his medications. -meal preparation for breakfast, lunch, supper, and two snacks. R1's initial nursing assessment dated June 11, 2024, indicated R1 was independent with smoking and inaccurately indicated he had no history of smoking concerns and no history of property damage due to smoking. The nursing assessment indicated R1 did not use drugs or alcohol. The assessment lacked any identification of medications R1 required, however indicated he	01640		

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01640	Continued From page 30 could safely self-administer them. The nursing assessment indicated R1 had verbal aggression and angry outbursts. R1's care plan dated June 11, 2024, indicated R1 was independent with bed mobility, transfers, bathing, dressing, eating, grooming, and ambulation. The care plan indicated staff would help prepare meals when needed. The care plan indicated nurses would help order R1's medications and remind him about his medications. The licensee inappropriately requested county payment for services for services R1 did not require including walking assistance, assistance with dressing, grooming and bathing. R1's service plan dated June 11, 2024, indicated the licensee would provide home health aide services "24/7", but lacked services listed on the 6790 document. The service plan lacked services for blood pressure monitoring and supervision for safety. R1's record lacked a service record for June 2024. R1's service record for July 2024, included services for housekeeping, laundry, meal preparation, reminders to bathe on Mondays and Wednesdays and behavioring monitoring. The record indicated indicated breakfast and lunch were prepared on July 1, 2024. The record indicated housekeeping services and meals were completed on July 6, 2024. The record lacked documentation all other days any services were provided. Law enforcement records dated June 26, 2024,	01640		

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01640	Continued From page 31 at 1:44 a.m., indicated officers arrived to the 4209 unit. R1 called them because his air conditioning was not functioning, and he had no hot water. R1 stated there are staff "next door" but they do not come by. The records indicated officers went to the 4213 unit, knocked and rang the doorbell several times, however no staff member (ULP) responded. Law enforcement looked through a window and observed an ULP sleeping. The ULP told law enforcement R1 came over several times and complained of a medical issue, so she called the nurse line, and no one answered. She then told R1 to go back to his room. The ULP informed the officers a manager told her they are not to assist the residents after a certain time during the night and she did not assist him with what he needed. R1 complained his blood pressure was high. The law enforcement officer told the ULP, she was a care giver, R1 tried to contact her several times through out the night to get assistance and she continued to ignore him. During law enforcement response, law enforcement directed the ULP to unit 4209 to take R1's blood pressure. On July 29, 2024, at 1:33 p.m., CM-A said she provided the licensee the county assessment . This assessment was an assessment based on what R1 required for care and services. The licensee reviewed the assessment, then provided the 6790 document. The licensee indicated they could provide care and services to R1 and moved him into their duplex home. R1 lived on one side of the duplex alone. CM-A said the licensee told R1 he would live alone, and staff members would be on the other side of the duplex. R1 told her the owner gave him money to buy his own groceries, pots, pans, and a toaster. At a meeting, the owner said one of the staff would bring R1 to the store to buy those items, but when CM-A talked to	01640		

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01640	Continued From page 32 R1 the next day, R1 said this did not happen. CM-A said there were multiple case notes and notes from R1 (almost every other day). CM-A said at the team meeting they discussed (and wrote out) an agreement indicating staff would have 24-hour access to the house, staff would knock before entering, safety checks through the day, a minimum of safety checks twice daily. CM-A said she never received proof staff checked on R1 a minimum of two times per day. CM-A said R1 indicated he was not getting assistance from the staff member. CM-A said R1 called law enforcement multiple times, and approximately one month later, CM-A helped R1 discharge from the licensee and admit into a crisis center. On July 30, 2024, at 9:25 a.m., registered nurse (RN)-B said she was not involved in R1 admission process to the licensee, but completed his initial nursing admission assessment. RN-B said R1 told her he had high blood pressure. RN-B said she did not determine what services R1 required, but decided with him. R1 said he was independent and could do his activities of daily living (ADLs) himself. R1 said he wanted to do his own laundry. RN-B said staff members told her he refused help from them. RN-B said if R1 required help, he would have to go to the other side of the duplex and ask staff member. RN-B said he had "free will." On July 31, 2024, at 2:33 p.m., licensed assisted living director (LALD)-D said the licensee had a team meeting about R1's needs and the team thought they could meet his needs. LALD-D said the licensee completed the 6790 document and submitted it to R1's case manager who agreed with admission. LALD-D said R1 was amicable and agreeable upon admission.	01640		

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01640	Continued From page 33 The licensee policy titled, Service Plan, dated August 1, 2021, indicated an individualized service plan would be implemented for all residents and the service plan would include a description of the services the licensee would provide. TIME PERIOD TO CORRECT: Seven (7) days.	01640		
01650 SS=D	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and	01650		

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01650	Continued From page 34 declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure service plans included a description of services to be provided, the fees for the service, the frequency of each service, according to the resident's current assessment and resident preferences, and identification of staff or categories of staff who will provide the services for one of one resident (R1) with records reviewed. 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) 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). Findings Include: R1 admitted to the licensee on June 11, 2024. R1's diagnoses included schizophrenia, post-traumatic stress disorder (PTSD), and antisocial personality disorder. R1's customized living rates worksheet (commonly known as 6790), dated June 4, 2024, indicated the licensee would provide these services to R1. The 6790 included the following services: -homemaking -shopping -assistance with making appointments -arranging non-medical transportation	01650		

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01650	Continued From page 35 -breakfast, lunch, supper, and two snacks -socialization -assistance with dressing, grooming, bathing, positioning, and walking -assistance with self-administration of medications -verbal and visual medication reminders -other delegated task: elevated blood pressure -medication set ups and monitoring -managing orientation issues -managing anxiety -managing agitation -manage verbal aggression -manage physical aggression -manage property destruction -meet other cognitive/mental health need: managing schizoaffective, bipolar type, chronic PTSD, and polysubstance abuse R1's service plan dated June 11, 2024, indicated the licensee would provide home health aide services "24/7. The service plan lacked services listed on the 6790 document and lacked: -a description of services to be provided -the fees for the service -the frequency of each service, according to the resident's current assessment and resident preferences. -identification of staff or categories of staff who will provide the services Additionally the service plan lacked a contingency plan to include: the action to be taken if the scheduled service cannot be provided; information and a method to contact the facility; the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and the circumstances	01650		

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01650	Continued From page 36 in which emergency medical services are not to be summoned. On July 31, 2024, at 2:33 p.m., licensed assisted living director (LALD)-D said he was involved in admitting R1 into the facility. LALD-D said the licensee was under pressure to receive a resident to meet licensure requirements. LALD -D acknowledged R1's services but said most of the time he only wanted reminders and did not want people doing things for him. LALD-D said the licensee had a "team" meeting about R1's needs and the team thought they could meet his needs. LALD-D said the licensee completed the 6790 document and submitted it to R1's case manager who agreed with admission. LALD-D said R1 was amicable and agreeable upon admission. The licensee policy titled, Service Plan, dated August 1, 2021, indicated an individualized service plan would be implemented for all residents and the service plan would include a description of the services the licensee would provide. TIME PERIOD TO CORRECT: Seven (7) days	01650		
01730 SS=G	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's	01730		

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01730	Continued From page 37 assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to contact R1's medical providers to obtain medication orders and therefore would have been unable to accurately assess R1's ability to self-administer medications	01730		

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01730	Continued From page 38 for one of one (R1) resident with records reviewed. The licensee inappropriately "deemed" R1 able to self-administer his own medications without knowing what medications R1 took or should have been taking. 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 admitted to the licensee on June 11, 2024. R1's diagnoses included schizophrenia, post-traumatic stress disorder (PTSD), and antisocial personality disorder. R1's service plan dated June 11, 2024, indicated the licensee would provide home health aide services "24/7. The service plan lacked medication administration, or other individualized service tasks. R1's customized living rates worksheet (commonly known as 6790) dated June 4, 2024, indicated the licensee would provide and receive payment for medication services to R1. The 6790 form indicated R1 required assistance with self-administration of medications because he took multiple medications and would forget to take some, or all of them. Staff would check on R1's medication record and prepare the prescribed medications as necessary. Staff would	01730		

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01730	Continued From page 39 document the medication administration and report any concerns about medications to the nurse. The 6790 form indicated R1 required medication management because his mental health symptoms impeded his ability to manage his medications. The 6790 indicated the licensee's nurse would review all R1's medications and the providers (physicians) orders for accuracy. The nurse would also set up R1's medications as prescribed and communicate with physicians. The 6790 form indicated staff would inform R1 of each medication given, and remind him to take medications as prescribed and scheduled. The 6790 form indicated R1 took several as needed "PRN" and staff would remind him to take those medications when he experienced "symptoms". The 6790 form indicated the licensee would remind R1 to take his medications at 7:00 a.m., 7:30 a.m., 8:00 a.m., 8:30 a.m., and 9:00 a.m. The 6790 form read as follows: "[R1] has been diagnosed with hypertension, a medical condition of elevated blood pressure. Unfortunately, he has demonstrated noncompliance in adhering to his prescribed medication regimen, thereby increasing the potential for severe health risks." The 6790 form indicated the nurse would take a lead role in education efforts to educate R1 in medication adherence. R1's initial nursing assessment dated June 11, 2024, indicated he had depression, anxiety, bipolar disorder, schizophrenia, delusions, and chronic obstructive pulmonary disease (COPD). The assessment indicated R1's blood pressure was 170/101. The assessment failed to identify any medications for R1, however indicated R1 was able to safely self-administer medications. The assessment indicated R1 would obtain a doctor order stating he could self-administer his	01730		

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01730	Continued From page 40 medications. R1's individual abuse prevention plan (IAPP) dated June 11, 2024, indicated R1 had anxiety and depression. The IAPP indicated the licensee's interventions would include R1 would have regular follow up visits with physicians and take prescribed medications as directed. Additionally, staff would notify the nurse promptly for any changes in his condition. R1's individualized medication management plan dated June 11, 2024, indicated the medication management services the licensee would provide to R1: medication reminders by staff, assistance with self-administering medications. The medication plan also indicated R1 was independent with medication administration. The medication plan indicated R1 safely stored his medications, and there were no special manufacture instructions for storage. The medication plan failed to identify any medications prescribed to R1. The summary paragraph at the conclusion of the medication management plan indicated R1's medication would be supervised by nursing and unlicensed personnel (ULP). The medication management plan failed to identify the licensee would provide medication set-up as indicated in the services identified by the 6790 form. The medication management plan failed to indicate staff would monitor R1's blood pressure and other monitoring related to R1's medication use. R1's case manager (CM)-A notes dated June 17, 2024, indicated the licensee contacted her for an emergency team meeting. The notes indicated the licensee would make copies of R1's medications and R1 would take his medications during scheduled wellness checks at 9:00 a.m.	01730		

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01730	Continued From page 41 and 9:00 p.m. each day. The notes indicated the licensee staff would observe R1 take his medications and chart his compliance. In addition, the licensee staff would check R1's blood pressure at 9:00 a.m., and 9:00 p.m., and chart his compliance. R1's progress notes dated June 18, 2024, though June 30, 2024, lacked any documentation staff observed, or reminded R1 to take his medications. The progress notes lacked consistent documentation staff checked, or attempted to check, his blood pressure twice daily. R1's medical records lacked a medication administration record (MAR). The licensee kept a binder in the duplex home, opposite where the resident resided. In the binder the surveyor located a calendar similar to a treatment administration record (TAR). The TAR indicated staff provided medication reminders on March 6, 2024 (Prior to R1's arrival into the licensee's facility). R1's nursing assessment dated June 26, 2024, lacked identification of any medications prescribed to R1. The assessment indicated R1 did not answer his door upon arrival of the nurse, but then came out of his room "yelling" and "cussing". The assessment indicated R1 was angry because he missed a medical appointment. The assessment indicated R1's blood pressure was 151/85. On July 25, 2024, at 9:52 a.m., surveyor sent owner (OW)-C an email and requested R1's physician orders. On July 27, 2024, at 2:51 p.m., licensed assisted living director (LALD)-D send	01730		

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01730	Continued From page 42 surveyor an email indicating the licensee attached documents. The documents provided lacked physician orders. On August 5, 2024, at 1:22 p.m., the surveyor requested R1's medication orders from his medical provider. R1's medical provider indicated their only record of R1 being seen by a medical provider was on May 6, 2024. The visit diagnoses included: moderate persistent reactive airway disease, hypertension, alcohol dependence, tobacco abuse, enlarged prostate, and urine retention. During this visit, a nurse practitioner renewed prescriptions for the following medications: -albuterol HFA (steroid inhaler) Take 2 puffs by mouth every six hours if needed for shortness of breath or wheezing. -amlodipine (for high blood pressure) 10 milligram (mg) tablet. Take 1 tablet by mouth once daily. -aspirin (for stroke precaution) 81 mg. Take one tablet by mouth once daily. -multivitamin. Take one tablet by mouth once daily. -pravastatin (for high cholesterol) 20 mg. Take 1 tablet at bedtime. -tamsulosin (for urine retention) 0.4 mg. Take 1 capsule by mouth once daily after a meal. -thiamine mononitrate (Vitamin B12) 100 mg. Take one tablet by mouth once daily. -losartan (for high blood pressure) 50 mg. Take 1 tablet by mouth once daily. On August 14, 2024, at 8:32 a.m., the surveyor received notification from R1's medical provider there were no records of him receiving further medical treatment from other medical providers within their system (including psychology) during the time he received services from the licensee.	01730		

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01730	Continued From page 43 On July 29, 2024, at 1:33 p.m., CM-A said she provided the licensee the county assessment. This was an assessment based on what R1 required for care and services. The licensee reviewed the assessment, then provided the 6790 document. The licensee indicated they could provide care and services to R1 and moved him into their duplex style home. R1 lived on one side of the duplex alone. CM-A said she had meetings with the licensee staff, and expectations for them to provide care/services to R1. CM-A said R1 called emergency services (911) multiple times and CM-A assisted in discharging R1 from the licensee to a crisis respite location. On July 30, 2024, at 9:25 a.m., registered nurse (RN)-B said she was not involved in R1 admission process until after R1 arrived. She then completed his initial nursing admission assessment. R1 told her he wanted to administer his own medications and RN-B told him he would have to get a letter from his physician indicating he was capable to self-administer his medications. RN-B said she did not observe any documentation from R1's medical providers and did not know what medications he required. RN-B said R1 told her he had high blood pressure and took blood pressure medications. RN-B said R1 did not attend medical appointments and did not obtain documentation from a physician indicating he could safely self-administer his medications. RN-B said she did not contact R1's medical providers and had no conversations with them. On August 15, 2024, at 7:53 a.m., probation officer (PO)-E said one of the court requirements for R1's probation was he take medications as prescribed by his medical providers and obtain a mental health evaluation. PO-E said the licensee staff was aware of the terms of R1's probation	01730		

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01730	Continued From page 44 and said the owner (OW)-C worked with R1 prior to placement into the licensee's duplex home. The licensee's policy titled, Assessment of Medications, dated August 1, 2021, indicated a registered nurse would provide and document a face-to-face assessment with the resident. The assessment would include identification of all medications, including over the counter medications. A medication reconciliation would include an accurate list of all the medications the resident took including the name, dose, frequency and route by comparing the resident record to an external list of medications obtained from the resident, hospital, prescriber or other provider. The licensee's policy titled, Medication Management Program, dated 2021, indicated licensee would communicate and coordinate with the prescriber and other providers involved with medication management. Medication reconciliation would include indication for medications. TIME PERIOD TO CORRECT: Seven (7) days.	01730		
02360	144G.91 Subd. 8 Freedom from maltreatment 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(s) reviewed (R1) was free from maltreatment.	02360	No plan of correction is required for this tag.	

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02360	Continued From page 45 Findings include: 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.	02360		