STATE LICENSING COMPLIANCE REPORT

Report #: HL304959338C

Date Concluded: October 12, 2023

Name, Address, and County of Facility Investigated:
Scandia Capital Partners LLC
102 North 58th Avenue West
Duluth, MN 55907
Saint Louis County

Facility Type: Assisted Living Facility with Dementia Care (ALFDC)

Evaluator's Name: Carol Moroney RN, Special Investigator
Rhylee Gilb, RN
Special Investigator

The Minnesota Department of Health conducted a complaint investigation to determine compliance with state laws and rules governing the provision of care under Minnesota Statutes, Chapter 144G. The purpose of this complaint investigation was to review if facility policies and practices comply with applicable laws and rules. No maltreatment under Minnesota Statutes, Chapter 626 was alleged.

To view a copy of the correction orders, if any, please visit: https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html, or call 651-201-4201 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached state form.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30495	A. BUILDING: _____ B. WING _____	C 10/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING	102 NORTH 58TH AVENUE WEST DULUTH, MN 55807

(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: #HL304959338C On October 4, 2023, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 10 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL304959338C tag identification 0750, 0990, and 1170.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 750 SS=D	144G.43 Subd. 5 Record retention Following the resident's discharge or termination of services, an assisted living facility must retain	0 750		

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0 750	Continued From page 1 a resident's record for at least five years or as otherwise required by state or federal regulations. Arrangements must be made for secure storage and retrieval of resident records if the facility ceases to operate. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to retain discharged resident records for one of one residents (R1) 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 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's record was reviewed. R1's service plan, undated and unsigned, indicated "see careplan" for services. R1's provider note dated January 5, 2023, indicated R1 was declining more rapidly with dementia. The note indicated at times over the past few weeks R1 seemed unable to walk and needed significant assistance with showering and dressing where she was independent prior. R1's progress notes were reviewed from July 18, [2022] through February 10, 2023, as provided by the licensee, indicated there were no changes in R1's ability. There were no notes between November 30, 2022 until February 10, 2023. On February 10, 2023, R1 was found on the floor, the unlicensed personnel (ULP) applied a transfer	0 750		

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0 750	Continued From page 2 belt, assisted R1 to stand and walked with (illegible word) to the bathroom. R1's incident report dated February 12, 2023, indicated R1 was found sitting on the floor, no injury noted. R1's care plan dated February 2023, indicated R1 received assistance with medications, treatments, reorientation with wandering, safety checks every two hours, showering and assistance as needed with dressing/grooming and toileting. R1's care plan indicated R1 walked independently with her walker. R1's discharge summary dated February 24, 2023, indicated the reason for discharge was R1 required a higher level of care with assistance of two staff. Home care service termination notice indication on the form was circled "no". The discharge location was a skilled nursing facility. R1's record lacked documentation reflecting a higher need in services to include assistance of two staff for cares. R1's record lacked documentation a prerequisite to termination of contract meeting was held with the resident and the resident's representative at least seven days prior to issuance of a discharge notice. R1's record lacked a written discharge notice. During an interview on October 5, 2023, at 8:12 a.m., executive director (ED)-A stated he did not work for the licensee at the time of R1's discharge and all of management has since been turned over as well.	0 750		

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0 750	Continued From page 3 During an interview on October 10, 2023, at 11:58 a.m., ED-A stated the only information related to R1's discharge was documented on the discharge record. ED-A stated he thought there was disagreement about R1 needing higher level of care, however there is no records of what happened during that period of time. TIME PERIOD OF CORRECTION: Seven (7) days.	0 750		
0 990 SS=D	144G.52 Subd. 2 Prerequisite to termination of a contract (a) Before issuing a notice of termination of an assisted living contract, a facility must schedule and participate in a meeting with the resident and the resident's legal representative and designated representative. The purposes of the meeting are to: (1) explain in detail the reasons for the proposed termination; and (2) identify and offer reasonable accommodations or modifications, interventions, or alternatives to avoid the termination or enable the resident to remain in the facility, including but not limited to securing services from another provider of the resident's choosing that may allow the resident to avoid the termination. A facility is not required to offer accommodations, modifications, interventions, or alternatives that fundamentally alter the nature of the operation of the facility. (b) The meeting must be scheduled to take place at least seven days before a notice of termination is issued. The facility must make reasonable efforts to ensure that the resident, legal representative, and designated representative are able to attend the meeting.	0 990		

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0 990	Continued From page 4 (c) The facility must notify the resident that the resident may invite family members, relevant health professionals, a representative of the Office of Ombudsman for Long-Term Care, a representative of the Office of Ombudsman for Mental Health and Developmental Disabilities, or other persons of the resident's choosing to participate in the meeting. For residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the facility must notify the resident's case manager of the meeting. (d) In the event of an emergency relocation under subdivision 9, where the facility intends to issue a notice of termination and an in-person meeting is impractical or impossible, the facility must use telephone, video, or other electronic means to conduct and participate in the meeting required under this subdivision and rules within Minnesota Rules, chapter 4659. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to conduct a prerequisite to termination of contract meeting with the resident and the resident's representative prior to discharge of one of one residents (R1) 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 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:	0 990		

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0 990	Continued From page 5 R1's record was reviewed. R1's service plan, undated and unsigned, indicated "see careplan" for services. R1's provider note dated January 5, 2023, indicated R1 was declining more rapidly with dementia. The note indicated at times over the past few weeks R1 seemed unable to walk and needed significant assistance with showering and dressing where she was independent prior. R1's progress notes were reviewed from July 18, [2022] through February 10, 2023, as provided by the licensee, indicated there were no changes in R1's ability. There were no notes between November 30, 2022 until February 10, 2023. On February 10, 2023, R1 was found on the floor, the unlicensed personnel (ULP) applied a transfer belt, assisted R1 to stand and walked with (illegible word) to the bathroom. R1's incident report dated February 12, 2023, indicated R1 was found sitting on the floor, no injury noted. R1's care plan dated February 2023, indicated R1 received assistance with medications, treatments, reorientation with wandering, safety checks every two hours, showering and assistance as needed with dressing/grooming and toileting. R1's care plan indicated R1 walked independently with her walker. R1's discharge summary dated February 24, 2023, indicated the reason for discharge was R1 required a higher level of care with assistance of two staff. Home care service termination notice indication on the form was circled "no". The discharge location was a skilled nursing facility. R1's record lacked documentation a prerequisite	0 990		

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0 990	Continued From page 6 to termination of contract meeting was held with the resident and the resident's representative at least seven days prior to issuance of a discharge notice. During an interview on October 4, 2023, at 12:44 p.m., family member (FM)-B stated on February 14, 2023, she visited R1 at the facility and saw her transported in a wheelchair. FM-B stated staff told her R1 had been falling a lot and they could not take care of her. FM-B said the facility had not informed her nor hospice of R1's falls. FM-B stated facility staff told her there is no staff to help the night nurse transfer R1 and was told R1 needed to move out. FM-B stated the facility never held a care conference with her or gave her a notice. During an interview on October 5, 2023, at 8:12 a.m., executive director (ED)-A stated he did not work for the licensee at the time of R1's discharge and all of management has since been turned over as well. During an interview on October 10, 2023, at 11:58 a.m., ED-A stated the only information related to R1's discharge was documented on the discharge record. ED-A stated he thought there was disagreement about R1 needing higher level of care, however there is no records of what happened during that period of time. TIME PERIOD OF CORRECTION: Seven (7) days.	0 990		
01170 SS=D	144G.56 Subd. 3 Notice required (a) A facility must provide at least 30 calendar	01170		

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01170	Continued From page 7 days' advance written notice to the resident and the resident's legal and designated representative of a facility-initiated transfer. The notice must include: (1) the effective date of the proposed transfer; (2) the proposed transfer location; (3) a statement that the resident may refuse the proposed transfer, and may discuss any consequences of a refusal with staff of the facility; (4) the name and contact information of a person employed by the facility with whom the resident may discuss the notice of transfer; and (5) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (b) Notwithstanding paragraph (a), a facility may conduct a facility-initiated transfer of a resident with less than 30 days' written notice if the transfer is necessary due to: (1) conditions that render the resident's room or private living unit uninhabitable; (2) the resident's urgent medical needs; or (3) a risk to the health or safety of another resident of the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a 30-day advance written notice to the resident, the resident's representative, the Office of Ombudsman for Long-Term Care, or the Office of the Ombudsman for Mental Health and Developmental Disabilities prior to initiating the termination of services and transfer of one of one resident (R1) discharged. This practice resulted in a level two violation (a violation that did not harm a resident's health or	01170		

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01170	Continued From page 8 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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's Uniform Consumer Information Guide indicated, the licensee provides comprehensive services included hands-on assistance with transfers and mobility. R1's record was reviewed. R1's service plan, undated and unsigned, indicated "see careplan" for services. R1's provider note dated January 5, 2023, indicated R1 was declining more rapidly with dementia. At times over the past few weeks R1 seemed unable to walk and needed significant assistance with showering and dressing where she was independent prior. R1's progress notes were reviewed from July 18, [2022] through February 10, 2023, as provided by the licensee, indicated there were no changes in R1's ability. There were no notes between November 30, 2022 until February 10, 2023. On February 10, 2023, R1 was found on the floor, the unlicensed personnel (ULP) applied a transfer belt, assisted R1 to stand and walked with (illegible word) to the bathroom. R1's incident report dated February 12, 2023, indicated R1 was found sitting on the floor, no injury noted. R1's care plan dated February 2023, indicated R1 received assistance with medications, treatments,	01170		

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01170	Continued From page 9 reorientation with wandering, safety checks every two hours, showering and assistance as needed with dressing/grooming and toileting. R1's care plan indicated R1 walked independently with her walker. R1's discharge summary dated February 24, 2023, indicated the reason for discharge was R1 required a higher level of care with assistance of two staff. Home care service termination notice indication on the form was circled "no". The discharge location was a skilled nursing facility. R1's record lacked documentation of 30-day written termination of services/contract notification. During an interview on October 4, 2023, at 12:44 p.m., family member (FM)-B stated on February 14, 2023, she visited R1 at the facility and saw her transported in a wheelchair. FM-B stated staff told her R1 had been falling alot and they could not take care of her. FM-B said the facility had not informed her nor hospice of R1's falls. FM-B stated facility staff told her there is no staff to help the night nurse transfer R1 and was told R1 needed to move out. FM-B stated the facility never held a care conference with her or gave her a notice. During an interview on October 10, 2023, at 11:58 a.m., executive director (ED)-A stated the only information related to R1's discharge was documented on the discharge record. ED-A stated he thought there was disagreement about R1 needing higher level of care, however there is no records of what happened during that period of time.	01170		

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01170	Continued From page 10 TIME PERIOD OF CORRECTION: Seven (7) days	01170		