STATE LICENSING COMPLIANCE REPORT

Report #: HL334151928C

Date Concluded: June 14, 2022

Name, Address, and County of Facility Investigated:
A-1 Reliable Home Care Inc.
1608 Carroll Avenue
St. Paul, MN 55104
Ramsey County

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

Evaluator's Name: Willette Shafer, 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
	33415	A. BUILDING: _____ B. WING _____	C 06/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A-1 RELIABLE HOME CARE INC	1608 CARROLL AVENUE SAINT PAUL, MN 55104

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0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL334151928C On June 1, 2022, 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 six residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for #HL334151928C, tag identification 510, 1140, 1240, and 1260.	0 000	Minnesota Department of Health is documenting the State Licensing 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.	
0 510 SS=F	144G.41 Subd. 3 Infection control program	0 510		

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0 510	Continued From page 1 (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. The deficient practice has the potential to affect all six residents. 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 all staff, residents, and visitors.) Findings include: Personal Protective Equipment (PPE) The licensee failed to ensure staff wore personal protective equipment (PPE) including medical grade face masks and eye protection while in resident care areas and within six feet of	0 510		

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0 510	Continued From page 2 unmasked residents (R1 and R3). An MDH document dated December 7, 2021, titled COVID-19 PPE and Source Control Grid for Congregate Care Settings by Community Transmission Level reads: PPE grid for health care workers, direct service care providers (i.e. includes employees, contractors, volunteers, etc); when community transmission levels are high or substantial, those working with residents without suspected or confirmed SARS-CoV-2 infection should wear a face mask and eye protection. The Centers for Disease Control (CDC) Integrated County View Data Tracker for COVID-19 listed the COVID-19 community transmission rate as "high" for Hennepin County at the time of the investigation. Upon surveyor entrance June 1, 2022, at 10:30 a.m., unlicensed personnel (ULP)-E and ULP-G met the surveyor at the rear entrance of the facility. ULP-E and ULP-G were not wearing a face mask or eye protection, and both were within six feet of R1 and R3. During an observation on June 1, 2022, at 10:45 a.m., ULP-E was observed standing in the kitchen next to R1. ULP-E lacked a surgical face mask and eye protection. During an interview on June 1, 2022, at 10:50 a.m., ULP-E stated staff were trained on COVID-19 and appropriate use of PPE. ULP-E did not respond when asked why staff were not wearing face masks or eye protection. During an observation on June 1, 2022, at 11:00 a.m., owner (OW)-A was observed sitting on the couch in the resident's living room without eye	0 510		

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0 510	Continued From page 3 protection. R3 was sitting within six feet of OW-A. During an interview on June 1, 2022, at 12:15 p.m., OW- A stated all staff must wear a face mask while in resident care areas. OW-A stated she was unaware eye protection must be worn while in resident care areas. OW-A said "oh" when the surveyor said multiple staff were observed not wearing face masks or eye protection in resident care areas. The licensee failed to provide a policy related to COVID-19 while onsite and again when requested via email. TIME PERIOD TO CORRECT: Two (2) Days	0 510		
01140 SS=I	144G.55 Subd. 3 Relocation plan required The facility must prepare a relocation plan to prepare for the move to the new location or service provider. This MN Requirement is not met as evidenced by: Based on interview and record review, licensee failed to prepare a relocation plan that included documentation of considerations for the care needs, psychosocial impacts of moving, and accounting of resident's property prior to initiating the transfer of two of two residents (R1 and R2) receiving assisted living services. R1 and R2 were transferred to a different facility. Due to the residents diagnoses, this violation had the potential to cause significant decline in the resident ' s physical and mental health. This practice resulted in a level three violation (a violation that harmed a resident's health or safety,	01140		

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01140	Continued From page 4 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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During an interview on June 1, 2022, at approximately 11:00 a.m., the owner (OW)-A said the residents were transferred to a different location because the facility's lease ended May 31, 2022. OW-A said she was notified on March 3, 2022, that the lease ended May 31, 2022. OW-A said the resident's case managers were notified of the move on May 18, 2022, and May 25, 2022, and that the residents were moved on May 31, 2022. The eviction notice dated March 4, 2022, indicated the lease ended May 31, 2022. The Minnesota Department of Health (MDH) received the licensee's document titled, Closure Form, signed by OW- A and dated April 22, 2022. The closure form indicated the proposed effective date of closure was April 30, 2022. The closure form indicated the reason for closure was due to "staffing issues/ hard to find staff" and "staffing problems." The closure form lacked an attached closure plan. An email correspondence from MDH to the licensee dated May 6, 2022, indicated MDH was following up with the licensee's plan for closure and indicated MDH had not yet received the licensee's closure plan and proposed notice to residents. The email indicated to the licensee:	01140		

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01140	Continued From page 5 "You are not allowed to take any action to close the residence until the commissioner's approval of the plan: -you should not notify residents of the proposed closure or take any action to carry out the closure until the plan is approved -you may not accept any new residents or enter into any additional assisted living contracts -no residents may be relocated until approval of the closure plan The document titled, Closure Plan and Proposed Notice to Residents is unacceptable and completely infringes on the residents' rights. -You may not simply dictate when/where residents are going to move to without providing them a choice, and provide two options in close proximity. Please refer to Rule 4659.0130 Subp. 2 E. -No closure, much less resident relocation may begin prior to the commissioner accepting your closure plan. -Per statute the resident's are required to receive a 60 day notice; not 30. -Per 144G.55 Subd. 2.Safe location. A safe location is not a private home where the occupant is unwilling or unable to care for the resident, a homeless shelter, a hotel, or a motel." An additional email correspondence from MDH to the licensee dated May 25, 2022, indiated MDH continued to follow up with the licensee inquiring if they still had intent of closure and MDH still had not received the requested information. An email sent by OW-A on May 27, 2022, to the Minnesota Department of Health indicated a relocation plan was not completed and attached an "Emergency Relocation Request." During an onsite on June 1, 2022, at 10:30 a.m.,	01140		

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01140	Continued From page 6 staff reported to the surveyor R2 was currently hospitalized due to mental health. R2's medical record was reviewed. R2's diagnoses include schizoaffective disorder and bipolar. R2's nursing care plan dated February 17, 2022, incidcated R2 was an elopement risk. Interventions included ensuring alarms on doors were working at all times because R2 had a history of leaving without notifying staff. During an interview on June 2, 2022, at 1:05 p.m., R2's mental health case manager (CM)-C said R2 notified him of the move the day R2 moved. CM-C said he called the licensee May 31, 2022. CM-C said the licensee said R2 was transferred to a different location because it was a better fit for R2's mental health. CM-C said he never received a phone call or email about R2 being relocated. During an interview on June 3, 2022, at approximately 10:45 a.m., R2 said she was told she would be moving a couple days before the move. R2 said she was not given a choice where she moved and would like to look for different housing. During an interview on June 6, 2022, at approximately 9:30 a.m., R2's cadi case manager (CCM)-D said she never received a phone call from the licensee about R2 being relocated. CCM-D said she received an email on May 30, 2022, that indicated R2 was being relocated. R1's medical record was reviewed. R1's care plan last reviewed February 23, 2022, indicated R1 was at risk for elopment due to history of leaving without notifying staff.	01140		

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01140	Continued From page 7 During an interview on June 6, 2022, at approximately 1:10 p.m., R1's family member (FM)-H said they were informed R1 moved on June 1, 2022. FM-H said they were not notified R1 was moving until after R1 moved. The licensee's undated Resident Discharge Process policy indicated the discharge plan will be discussed with the physician and resident/ resident representative prior to discharge. TIME PERIOD FOR CORRECTION: Two (2) days	01140		
01240 SS=F	144G.57 Subd. 3 Commissioner's approval required prior to imp (a) The plan shall be subject to the commissioner's approval and subdivision 6. The facility shall take no action to close the residence prior to the commissioner's approval of the plan. The commissioner shall approve or otherwise respond to the plan as soon as practicable. (b) The commissioner may require the facility to work with a transitional team comprised of department staff, staff of the Office of Ombudsman for Long-Term Care, and other professionals the commissioner deems necessary to assist in the proper relocation of residents. This MN Requirement is not met as evidenced by: Based on document review and interview, the licensee failed to provide notice of intent to close the facility to the commissioner before initiating the process of facility closure. This affected two of two residents (R1 and R2).	01240		

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01240	Continued From page 8 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). Findings Include: On May 11, 2021, owner (OW)-A submitted a signed application to the Minnesota Department of Health on behalf of licensee acknowledging the licensee reviewed and understood Minnesota Statutes, Rules, and requirements related to assisted living licensure. On August 1, 2021, licensee was issued an Assisted Living Facility/with Dementia Care license. The eviction notice dated March 4, 2022, indicated the lease ended May 31, 2022. The Minnesota Department of Health (MDH) received the licensee's document titled, Closure Form, signed by OW- A and dated April 22, 2022. The closure form indicated the proposed effective date of closure was April 30, 2022. The closure form indicated the reason for closure was due to "staffing issues/ hard to find staff" and "staffing problems." The closure form lacked an attached closure plan. An email correspondence from MDH to the licensee dated May 6, 2022, indicated MDH was following up with the licensee's plan for closure and indicated MDH had not yet received the licensee's closure plan and proposed notice to	01240		

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01240	Continued From page 9 residents. The email indicated to the licensee: "You are not allowed to take any action to close the residence until the commissioner's approval of the plan: -you should not notify residents of the proposed closure or take any action to carry out the closure until the plan is approved -you may not accept any new residents or enter into any additional assisted living contracts -no residents may be relocated until approval of the closure plan The document titled, Closure Plan and Proposed Notice to Residents is unacceptable and completely infringes on the residents' rights. -You may not simply dictate when/where residents are going to move to without providing them a choice, and provide two options in close proximity. Please refer to Rule 4659.0130 Subp. 2 E. -No closure, much less resident relocation may begin prior to the commissioner accepting your closure plan. -Per statute the resident's are required to receive a 60 day notice; not 30. -Per 144G.55 Subd. 2.Safe location. A safe location is not a private home where the occupant is unwilling or unable to care for the resident, a homeless shelter, a hotel, or a motel." An additional email correspondence from MDH to the licensee dated May 25, 2022, indiated MDH continued to follow up with the licensee inquiring if they still had intent of closure and MDH still had not received the requested information. An email sent by OW-A on May 27, 2022, to the Minnesota Department of Health indicated a relocation plan was not completed and attached an "Emergency Relocation Request."	01240		

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01240	Continued From page 10 During an interview on June 1, 2022, at approximately 11:00 a.m., OW-A stated she initially completed the Minnesota Department of Health's Closure Form but then decided she should have completed relocation documents. OW-A said a closure plan was not completed. OW-A said the residents needed to relocate because the property management company refused to renew the facility's lease. OW-A said she was notified the lease would not be renewed on March 3, 2022. OW-A said the lease ended May 31, 2022. The licensee had more than 60 days to complete a proper closure plan and 60 day closure of facility notice to residents. In an email dated May 27, 2022, at 2:20 p.m., OW-A indicated she planned to move the residents due to imminent risk of being homeless. The email indicated she would follow the process for closing the location. The licensee did not provide a policy related to facility closure. TIME PERIOD FOR CORRECTION: Two (2) Days	01240		
01260 SS=F	144G.57 Subd. 5 Notice to residents After the commissioner has approved the relocation plan and at least 60 calendar days before closing, except as provided under subdivision 6, the facility must notify residents, designated representatives, and legal representatives of the closure, the proposed date of closure, the contact information of the ombudsman for long-term care, and that the	01260		

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01260	Continued From page 11 facility will follow the termination planning requirements under section 144G.55, and final accounting and return requirements under section 144G.42, subdivision 5. For residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the facility must also provide this information to the resident's case manager. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to provide residents, the ombudsman of long-term care, and case managers, a written closure notification at least 60 calendar days before initiating the facility closure. This affected two of two residents (R1 and R2). 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). Findings Include: On May 11, 2021, owner (OW)-A submitted a signed application to the Minnesota Department of Health on behalf of licensee acknowledging licensee reviewed and understood Minnesota Statutes, Rules, and requirements related to assisted living licensure. On August 1, 2021, licensee was issued an Assisted Living Facility/with Dementia Care license.	01260		

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01260	Continued From page 12 The Minnesota Department of Health received the licensee's document titled, Closure Form, as well as an attachment, signed by OW-A and dated April 22, 2022. The closure form indicated the proposed effective date of closure was April 30, 2022. During an interview on June 1, 2022, at approximately 11:00 a.m., OW- A said she was notified on March 3, 2022, that the lease ended May 31, 2022. OW-A said the resident's case managers were notified of the transfer on May 18, 2022, and May 25, 2022. OW-A said she told the case managers she was having "problems with the landlord." OW-A said she sent an email to the case managers on May 30, 2022, that indicated the residents would be moved to a different location. During an interview on June 2, 2022, at 1:05 p.m., R2's mental health case manager (CM)-C said he never received a phone call or email about R2 being relocated. CM-C said R2 notified him she had moved on May 31, 2022. CM-C said he called the licensee on May 31, 2022, after he spoke to R2. CM-C said the licensee told him R2 was transferred to a different location because it was a better fit for R2's mental health. CM-C said the resident was in the hospital due to a mental health crisis triggered by stress. During an interview on June 3, 2022, at approximately 10:45 a.m., R2 said she was told she would be moving a couple days before the move. R2 said she was not given a choice where she moved and would like to look for different housing. During an interview on June 6, 2022, at	01260		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33415	A. BUILDING: _____ B. WING _____	C 06/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A-1 RELIABLE HOME CARE INC	1608 CARROLL AVENUE SAINT PAUL, MN 55104

(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
01260	Continued From page 13 approximately 9:30 a.m., R2's cadi case manager (CCM)-D said she never received a phone call from the licensee about R2 being relocated. CCM-D said she received an email on May 30, 2022, that indicated R2 was being relocated. CCM-D said R2 was never given a choice about the relocation. During an interview on June 6, 2022, at approximately 1:10 p.m., R1's family member (FM)-H said they were informed R1 moved on June 1, 2022. FM-H said they were not notified R1 was moving until after R1 moved. During an interview on June 6, 2022, at approximately 2:00 p.m., the ombudsman said they received notice of transfer on May 22, 2022. The ombudsman said the licensee should have provided notice at least 60 days before transferring the resident. The licensee's undated Resident Transfer policy indicated the resident/ caregiver shall be given the opportunity to participate in the decision-making process and transfer arrangements and the Registered Nurse shall inform the resident/caregiver of the need for transfer/ discharge from the facility. TIME PERIOD FOR CORRECTION: Two (2) Days	01260		