

STATE LICENSING COMPLIANCE REPORT

Report #: HL345159764C

Date Concluded: February 20, 2025

Name, Address, and County of Facility

Investigated:

Derman Senior Care Inc.
2218 Doswell Avenue
St Paul, MN 55108
Ramsey County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: James Larson, 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.

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34515	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/13/2024
NAME OF PROVIDER OR SUPPLIER DERMAN SENIOR CARE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 2218 DOSWELL AVENUE FALCON HEIGHTS, MN 55108			
(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: On December 13, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL345159764C. No correction orders are issued. #HL345159808C/#HL345156563M On December 13, 2024, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 104 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued/orders are issued for #HL345159808C/#HL345156563M, tag identification 2350.	0 000	Assisted Living Provider 144G. 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.		

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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02350	Continued From page 1	02350			
02350 SS=D	144G.91 Subd. 7 Courteous treatment Residents have the right to be treated with courtesy and respect, and to have the resident's property treated with respect This MN Requirement is not met as evidenced by: Based on observation, interview and record review the licensee failed to treat a resident (R1) with courtesy and respect when a facility staff member, the alleged perpetrator (AP) was seen on a surveillance camera yelling at R1. 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: R1's diagnosis included schizoaffective disorder, antisocial personality disorder, and generalized anxiety disorder. R1's service plan dated December 19, 2024, indicated R1 received services to include medication management, assistance with housekeeping, laundry, and safety checks. R1's Individual Abuse Prevention Plan (IAPP) dated November 22, 2024, indicated R1 is a vulnerable adult and is risk for abuse or neglect. Staff have been trained on signs and symptoms of abuse and neglect and should report immediately to registered nurse or director. The	02350			

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02350	Continued From page 2 IAPP indicated R1 had a history of verbally aggression, requiring staff to redirect the client and give him space to calm down. Video surveillance footage showed a verbal altercation between R1 and the AP, a facility administrator (AD)-B. The video was recorded by a facility camera placed in the upper corner of the administration office located on the 2nd floor of the facility and time stamped October 22, 2024, 12:32 p.m. The video footage shows R1 seated at a desk inside the facility office area on the second floor. R1 can be heard on video asking the AP (AD-B) to use a cell phone to make personal call. R1 stated, "phones don't work, there are no working phones here, I need to use a phone, can I please use your phone." After repeated requests by R1 to use a phone, the AP (AD-B) repeatedly points at the office doorway with a handheld phone in his hand while raising his voice and demands the resident leave his office. The verbal altercation extends into the common hallway where the AP (AD-B) and R1 continue to yell at each other over the availability of a phone. R1 can be again heard asking, "can I please use your phone", and the AP replies NO! During an interview on January 9, 2025, the AP (AD-B) stated that he did not recall this specific incident with R1. The licensee's Minnesota Bill of Rights for Assisted Living Residents dated November 08, 2022, provided to staff during training and residents upon admission included residents	02350			

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02350	Continued From page 3 have the right to be treated with courtesy and respect. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	02350			