Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL359887522M
Compliance #: HL359889402C

Date Concluded: January 21, 2025

Name, Address, and County of Licensee Investigated:
Noah Home Care
13521 Nicollet Lane
Burnsville, MN 55337
Dakota County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Kris Detsch, RN
Special Investigator

Finding: Inconclusive

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 neglected a resident when they failed to provide meals. As a result, the resident went to the food shelf to obtain food items. Additionally, the facility neglected a resident when they failed to provide transportation, or access to a phone.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. The facility ordered food items by Instacart (an online food delivery system). Instacart records indicated the facility ordered food items for delivery to the facility prior to the resident going to the food shelf. However, it could not be determined if the food items were sufficient to sustain a weekly menu. The resident suffered no harm. Additionally, law enforcement took the resident's phone which impacted his ability to obtain transportation via Lyft (a ride system). The facility had a land line phone.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted case workers. The investigation included review of the resident records, personnel files, and related facility policy and procedures. Also, the investigator toured the facility and observed food storage areas.

The resident resided in an assisted living facility. The resident's diagnoses included depression and anxiety. The resident's service plan included assistance with dressing, grooming, and behavior management. The resident's assisted living contract and service plan indicated he required meal assistance, and the facility was required to provide three meals per day with two snacks. The resident's nursing assessment indicated he was alert and orientated. The resident walked without assistance and communicated his needs.

The resident's records included a support plan from the county. The support plan included services the resident received from the county and indicated the resident received $500.00 per month to use Lyft services for transportation to and from work. The support plan indicated if Lyft was unable to provide transportation, then the resident would take public transportation or call his case worker to help him find transportation.

Instacart food delivery records indicated the facility received $317.22 (55 food items) two days prior to the resident going to the food shelf, $263.00 (48 food items) seven days prior to him going to the food shelf, $353.30 (64 items) five days prior to him going to the food shelf, and $454.13 (70 items) one day prior to him going to the food shelf. Overall, review of food delivery records indicated the facility ordered food items weekly, sometimes multiple times during the week.

During an onsite visit, the facility refrigerator was observed. The facility had raw meat available for cooking meals, however the refrigerator lacked adequate fruits and vegetables for snacks and sides. The facility did not have available food items for the menu posted and the menu was not specific to a date, just the seven days of the week listed. The unlicensed personnel (ULP) responsible for cooking for residents stated he did not prepare food based on the menu, just what meal the residents' agreed on for the day.

During an interview, a case manager said the resident told her the facility did not provide the foods he liked, so she asked the staff members if the resident could participate with grocery shopping. The case manager said staff members told her none of the residents participated with grocery shopping because the facility ordered groceries online (through the computer). The case manager said if the resident participated in grocery shopping, it could have reduced his behaviors. The case manager said she got a lot of "push back" from the staff about this request. The case manager said another case worker took the resident to the food shelf because there was not enough food in the facility. The case manager said the facility received money to provide the resident three meals per day and snacks.

During an interview, a case worker said the resident worked at a grocery store and his shift ended late in the evening. Staff members told the resident he could not cook food in the evening or eat food in his room. The case worker said she took the resident to the food shelf (twice) because he told her there was no food in the facility he would eat. The case worker said she went into the facility and had the resident showed her the facilities food supply. The case worker said she saw a lot of noodles, which is what another resident liked to eat. She also saw food items labeled with another resident's name. The case worker said she saw fruits and vegetables, but they looked poor, and the food items were things the resident would not eat. The case worker said the food shelf provided essential items to the resident such as milk and eggs. The case worker said the resident cooked his own meals and she did not know if the facility cooked any meals for him.

During an interview, a manager said the facility ordered groceries weekly from Instacart and any staff member could order grocery items at any time. The manager said Instacart delivers the groceries to the facility the same day the facility ordered them. The manager said she talked with each resident weekly and incorporated their food choices into the facility's weekly menu. The manager said was aware the resident went to the food shelf; however, it was his choice to go, and she could not prevent him. The manger said the resident did not need to go to the food shelf because there was a sufficient food supply at the facility. The manager said the resident used Lyft service for transportation to and from the facility for work and he scheduled his own transportation. The manager said the facility provided transportation for him for his personal use such as shopping and medical appointments.

During an interview, the resident said the facility staff members were preparing the meals currently. The resident said the facility staff members prepared the meals with "little care", and they overcook foods, so he prepares his meals to his preference. The resident said he was supposed to make a list of the groceries/meals he wanted and give it to the staff members, but he was unsure if the staff members kept the list. The resident said the facility provided food, but there were times they lacked ingredients, so he got those ingredients from the food shelf. The resident said the facility did not provide food in accordance with the dietary guidelines of the food pyramid (table of recommended dietary servings) and the facility menu never changed. The resident said he gained over thirty pounds in the past few months, but he attributed the weight gain to his lack of mobility. The resident said law enforcement took his phone from him, which made it harder for him to get around because he used Lyft service for transportation to and from work. The resident said the facility needed to have one staff member at the facility, so transportation was difficult for him during this time, but he said it was not the facility's fault. The resident said the facility took him to medical appointments.

In conclusion, the Minnesota Department of Health determined neglect was inconclusive.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or did not occur.

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.

Vulnerable Adult interviewed: Yes.
Family/Responsible Party interviewed: No. Attempted, but did not reach.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility ordered foods weekly from Instacart.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35988	A. BUILDING: _____ B. WING _____	C 12/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOAH HOME CARE INC	13521 NICOLLET LANE BURNSVILLE, MN 55337

(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: HL359889402C/HL359887522M On December 10, 2024 through December 11, 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 three residents receiving services under the provider's Assisted Living license. The following correction orders are issued for HL359889402C/HL359887522M, tag identification 480, 485.	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.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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0 480	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are	0 480		

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to adhere to the Minnesota Food Code, Minnesota Rules, chapter 4626. The licensee failed to separate raw animal foods (meat) from ready-to-eat foods (fruits/vegetables) in the refrigerator. This deficient practice had the potential to affect all three residents of the facility. 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 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: On December 10, 2024, at 8:08 a.m., the surveyor entered the licensee and observed the licensee's refrigerator. The surveyor observed two cartons of raw/uncooked eggs next to a package of red grapes. The two items were	0 480		

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0 480	Continued From page 3 touching. The grapes had visible mold within the package. The surveyor observed the second shelf and saw a package of raw chicken next to a bag of oranges. The two items were touching, and not separated by any compartment. The surveyor observed a package of lunch meat sitting on top of the of package of raw chicken. The surveyor observed the drawer below the second shelf and saw raw/uncooked hamburger, a package of beef, and other raw/uncooked meat items. The drawer contained a bag of red grapes next to the raw/uncooked hamburger and a package of raw/uncooked beef was on top of the bag of red grapes. On December 11, 2024, at 2:30 p.m., owner (OW)-C said she was the food manager and completed all tasks related to food and infection control. OW-C said she made sure the food storage was correct and educated staff members about food safety. OW-C acknowledged raw foods should not be touching ready to eat items. The licensee's policy titled, Food Service, dated August 1, 2021, indicated the licensee would adhere to the Minnesota Food Code, Minnesota Rules, chapter 4626. TIME PERIOD OF CORRECTION: Twenty-one (21) days	0 480		
0 485 SS=F	144G.41 Subdivision 1.a (a) Minimum requirements; required food services All assisted living facilities must offer to provide or make available 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	0 485		

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0 485	Continued From page 4 Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The 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 food that is served. Residents must be informed in advance of menu changes. The facility must not require a resident to include and pay for meals in the resident's contract. This MN Requirement is not met as evidenced by: Based on observation, and interview, the licensee failed to prepare and provide meals to residents, failed to provide a menu at least one week in advance and make available to all residents for one of one residents (R1) reviewed. R1 had to obtain food from the food shelf to make meals. This had the potential to affect all three residents at the facility. 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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 admitted to the licensee for diagnoses including depression and anxiety. R1's assisted living contract dated May 6, 2023, indicated the licensee would provide three meals	0 485		

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0 485	Continued From page 5 per day and post a weekly menu. The contract indicated the resident would be informed in advance of any changes to the menu. The contract also indicated snacks would be available, and the resident would have access to food at any time. R1's service plan dated December 10, 2024, indicated R1 required meal assistance daily. On December 10, 2024, at 8:08 a.m., the surveyor entered the licensee and observed a weekly menu posted on a cupboard in the kitchen. The menu included the seven days of the week, but failed to include a date for the days. Each day of the week consisted of items for breakfast, appetizer/snack, lunch, and dinner. The menu for "Tuesday" (December 10, 2024), indicated the following: Breakfast: Offerings and Pastry Appetizer/snack: Chunky Spiced Applesauce or Garden Salad Lunch: Parmesan Crusted Fish Filet with lemon and Tarter, Roasted Reds, Squash, Pudding Parfait Dinner: Egg Salad Sandwich with Lettuce and Sweet Pickle, Oreo Blondie The surveyor observed the licensee's food storage areas including the refrigerator, freezer, cupboards. The surveyor observed the licensee did not have the food items required to make meals as listed on the menu. The surveyor did not observe pastry, apple sauce, roasted reds, squash, pudding, or Oreo Blondie. On December 10, 2024, at 8:59 a.m., unlicensed personnel (ULP)-F said when the residents wake up in the morning, they agree on a meal, and he prepares it for them. ULP-F said he did not prepare food from the menu and asked the	0 485		

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0 485	Continued From page 6 surveyor to talk with the owner about it because he was not sure about the menu. ULP-F acknowledged he was the only staff working during the day, and responsible for preparing the food On December 11, 2024, at 12:48 p.m., R1 said the licensee did not prepare food as listed on the menu and the posted menu did not change. R1 said he prepared his own meals, however lacked ingredients to make complete meals and went to the food shelf to obtain those items. On December 11, 2024, at 2:30 p.m., Owner (OW)-A said the licensee had a standard menu, and a menu is always available. OW-A said there were two different types of lunch provided to the residents on the day the surveyor arrived (December 10, 2024). OW-A said the licensee offers three meals per day, and two snacks. OW-A said the staff do a wonderful job telling the residents what is for lunch ahead of time, then they make substitutions. The licensee's policy titles, Food Service, dated August 1, 2021, indicated the licensee would prepare a menu at least one week in advance and make it available to all residents and notify them, in advance, of the changes to the menu. Time period for correction: Twenty-one (21) days.	0 485		