STATE LICENSING COMPLIANCE REPORT

Report #: HL36541003C **Date Concluded: August 15, 2022**

Name, Address, and County of Facility Investigated:
Bright Path Homes
1001 65th Avenue North
Brooklyn Center, MN 55430
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Erin Johnson-Crosby, 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
	36541	A. BUILDING: _____ B. WING _____	C 08/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHT PATH HOMES	1001 65TH AVENUE NORTH BROOKLYN CENTER, MN 55430

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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: #HL36541003C On August 8, 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 4 residents receiving services under the provider's Assisted Living license. The following correction orders are issued for #HL36541003C, tag identification 1040, 1060 and 1070.	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	

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0 000	Continued From page 1	0 000	REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
01040 SS=D	144G.52 Subd. 7 Notice of contract termination required (a) A facility terminating a contract must issue a written notice of termination according to this section. The facility must also send a copy of the termination notice to the Office of Ombudsman for Long-Term Care and, for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, to the resident's case manager, as soon as practicable after providing notice to the resident. A facility may terminate an assisted living contract only as permitted under subdivisions 3, 4, and 5. (b) A facility terminating a contract under subdivision 3 or 4 must provide a written termination notice at least 30 days before the effective date of the termination to the resident, legal representative, and designated representative. (c) A facility terminating a contract under subdivision 5 must provide a written termination notice at least 15 days before the effective date of the termination to the resident, legal representative, and designated representative. (d) If a resident moves out of a facility or cancels services received from the facility, nothing in this section prohibits a facility from enforcing against the resident any notice periods with which the resident must comply under the assisted living contract. This MN Requirement is not met as evidenced by:	01040		

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01040	Continued From page 2 Based on interview and record review, the licensee failed to issue a written notice for a termination of contract at least 30 days ahead of the termination, or at least 15 days ahead of an expedited termination, and failed to provide documentation supporting the need for an expedited termination of their contracts for one of one (R1) former resident with records reviewed. R1's contract was terminated without notice after being sent to the hospital. In addition, the licensee failed to send a copy of the termination notice to the Office of Ombudsman for Long Term Care. 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 discharge summary from the previous facility indicated R1 was discharged to the licensee on January 3, 2022. R1's health status at discharge indicated R1 was hospitalized three times in the last year for delusions, aggressive behavior, substance abuse, intrusive behavior and medication non-compliance. R1 was admitted to the licensee on January 3, 2022, with diagnoses that included schizophrenia, bipolar disorder, auditory hallucinations, poly-substance abuse and delusions. R1's service plan dated January 3, 2022, indicated R1 received services for medication management,	01040	Assisted Living Provider 144G. 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.	

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01040	Continued From page 3 meal prep, laundry, housekeeping, and supervision for grooming and dressing. The service plan also indicated if R1 became aggressive, staff should have R1 go to her room. If R1 does not calm down or is threatening, staff should call 911 and inform the nurse. The same document indicated staff were to encourage R1 to stay sober. R1's progress notes dated February 13, 2022, indicated R1 was swearing at the unlicensed personnel (ULP)-B and threatened to slap ULP-B. R1 then took a bowl and hit the staff on the thumb. ULP-B told R1 if she did not stop with the behaviors ULP-B was going to call the police. ULP-B called the police and R1 was taken to the hospital. R1's discharge summary dated February 13, 2022, indicated R1 refused medications throughout the stay at the facility and was discharged to the hospital for an assault on staff. On August 8, 2022, at 12: 36 p.m., licensed assisted living director (LALD)-A stated the licensee considered the incident on February 13, 2022, an emergency discharge since R1 assaulted staff. LALD-A confirmed the licensee did not contact the ombudsman or provide a 15 day termination notice to R1, R1's legal representative or R1's designated representative. The licensee's Discharge and Transfer of Residents policy dated August 1, 2021, indicated a written notice of an expedited contract termination will be issued to the resident, the resident's legal representative and the resident's designated representative at least 15 days before the effective date or termination.	01040		

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01040	Continued From page 4 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01040		
01060 SS=D	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and	01060		

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01060	Continued From page 5 (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, licensee failed to provide documentation of a written notice which contained the required content for an emergency relocation for one of one former resident (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, 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 discharged or deceased client roster dated, February 15, 2022, indicated R1 was admitted on January 3, 2022, and discharged to the hospital on February 13, 2022. The document indicated service termination was provided verbally. R1's discharge summary from the previous facility indicated R1 was discharged to the licensee on January 3, 2022. R1's health status at discharge indicated R1 was hospitalized three times in the last year for delusions, aggressive behavior,	01060		

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01060	Continued From page 6 substance abuse, intrusive behavior and medication non-compliance. R1 was admitted to the licensee on January 3, 2022, with diagnoses that included schizophrenia, bipolar disorder, auditory hallucinations, poly-substance abuse and delusions. R1's service plan dated January 3, 2022, indicated R1 received services for medication management, meal prep, laundry, housekeeping, and supervision for grooming and dressing. The service plan also indicated if R1 became aggressive, staff should have R1 go to her room. If R1 does not calm down or is threatening, staff should call 911 and inform the nurse. The same document indicated staff were to encourage R1 to stay sober. R1's progress notes dated February 13, 2022, indicated R1 was cursing at the unlicensed personnel (ULP)-B and threatened to slap ULP-B. R1 then took a bowl and hit the staff on the thumb. ULP-B told R1 if she did not stop the behaviors ULP-B was going to call the police. ULP-B called police and R1 was taken to the hospital. R1's discharge summary dated February 13, 2022, indicated R1 refused medications throughout the stay at the facility and was discharged to the hospital for an assault on staff. The licensee lacked documentation providing a reason for the relocation, and a written notice providing the required minimums: -reason for relocation; -name and contact information for the location to which the resident has been relocated and any new service provider; -contact information for the Office of Ombudsman	01060		

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01060	Continued From page 7 for Long-Term Care; -if known and applicable the approximate date or range or dates within which the resident is expected to return or a statement the return date is unknown; -a statement if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144.54. The facility must provide contact information for the agency to which the resident may submit an appeal; -the notice) must be delivered as soon as practicable to: -the resident, legal representative, and designated representative; -for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; -the Office of Ombudsman for Long-Term Care if the resident has been relocated. On August 8, 2022, at 12:36 p.m., licensed assisted living director (LALD)-A stated R1 was discharged to the hospital for assaulting a staff member and considered R1's discharge an emergency. LALD-A stated the licensee did not provide a written discharge notice to R1, R1's legal representative or R1's designated representative. The licensee's Discharge and Transfer of Residents policy dated August 1, 2021, indicated the licensee may remove a resident in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another resident or staff member. The policy also indicated an emergency relocation is not a termination and if there is an emergency relocation and the licensee	01060		

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01060	Continued From page 8 will issue a notice of termination following the relocation and determination meeting would be conducted. The same document indicated following an emergency relocation the licensee's refusal to provide housing or services constitutes a termination and triggers the termination process. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01070 SS=D	144G.52 Subd. 10 Right to return If a resident is absent from a facility for any reason, including an emergency relocation, the facility shall not refuse to allow a resident to return if a termination of housing has not been effectuated. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee infringed upon a resident's right to return to the facility following an emergency relocation without providing a written notice of termination for one of one (R1) residents 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).	01070		

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01070	Continued From page 9 The findings include: The licensee's discharged or deceased client roster dated, February 15, 2022, indicated R1 was admitted on January 3, 2022, and discharged to the hospital on February 13, 2022. The document indicated a service termination was provided verbally. R1's discharge summary from the previous facility indicated R1 was discharged to the licensee on January 3, 2022. R1's health status upon admission indicated R1 was hospitalized three times in the last year for delusions, aggressive behavior, substance abuse, intrusive behavior and medication non-compliance. R1 was admitted to the licensee on January 3, 2022, with diagnoses which included schizophrenia, bipolar disorder, auditory hallucinations, poly-substance abuse and delusions. R1's service plan dated January 3, 2022, indicated R1 received services for medication management, meal prep, laundry, housekeeping, and supervision for grooming and dressing. The service plan also indicated if R1 became aggressive, staff should have R1 go to her room. If R1 does not calm down or is threatening, staff should call 911 and inform the nurse. The same document indicated staff were to encourage R1 to stay sober. R1's progress notes dated February 13, 2022, indicated R1 was cursing at the unlicensed personnel (ULP)-B and threatened to slap ULP-B. R1 then took a bowl and hit the staff on the thumb. ULP-B told R1 if she did not stop the behaviors ULP-B was going to call the police. ULP-B called the police and R1 was taken to the hospital.	01070		

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01070	Continued From page 10 R1's discharge summary dated February 13, 2022, indicated R1 refused medications throughout the stay at the facility and was discharged to the hospital for an assault on staff. On August 8, 2022, at 12: 36 p.m., licensed assisted living director (LALD)-A stated the licensee considered the incident on February 13, 2022, an emergency discharge since R1 assaulted staff and as a result, refused to allow the resident to return to the facility. LALD-A confirmed the licensee did not contact the ombudsman or provide a 15 day termination notice to R1, R1's legal representative or R1's designated representative. The licensee's Discharge and Transfer of Residents policy dated August 1, 2021, indicated the licensee may remove a resident in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another resident or staff member. The policy also indicated an emergency relocation is not a termination and if there is an emergency relocation and the licensee will issue a notice of termination following the relocation and determination meeting would be conducted. The same document indicated following an emergency relocation the licensee's refusal to provide housing or services constitutes a termination and triggers the termination process. The licensee's Right to Return policy dated August 1, 2020 indicated if a resident is absent from the facility for any reason, the facility would not refuse to allow the resident to return if a termination of housing has not been implemented.	01070		

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01070	Continued From page 11 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01070		