

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** HL367543503M  
**Compliance #:** HL367543779C

**Date Concluded:** August 29, 2024

**Name, Address, and County of Licensee**

**Investigated:**

Midwest Group Home  
4232 5<sup>th</sup> Street Northeast  
Columbia Heights, MN 55421  
Anoka County

**Facility Type:** Assisted Living Facility (ALF)

**Evaluator's Name:** Lissa Lin, 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 resident 1 when resident 2 and an unknown male visitor physically threatened and abused resident 1. Resident 1 sustained a bruised forehead.

**Investigative Findings and Conclusion:**

The Minnesota Department of Health determined neglect was inconclusive. The facility reported suspected abuse involving resident 1, resident 2 and an unidentified male visitor. The facility lacked a written policy and procedure in place on performing and documenting resident safety checks and there was no documentation of the service, however staff stated they did safety checks the night of the incident. The owner also stated she asked the visitor to leave when he was bothering staff and residents. The facility also requested no trespassing orders of the visitor. Interviews produced conflicting information on the alleged abuse incident and resident 1 refused examination by a medical provider. Resident 1 sustained a bruised forehead and returned to her baseline health.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident records, clinic records, facility incident reports, staff schedules, a law enforcement report, and related facility policy and procedures. Also, the investigator observed resident 1 and resident 2 at the facility interacting with staff and each other.

Resident 1 lived in an assisted living facility. Her medical diagnoses were depression and post-traumatic stress disorder (PTSD). Resident 1's service plan indicated she received medication administration and safety checks three times daily. Resident 1 used a cane and a wheeled walker to walk due to hip pain from past hip surgery. The nurse assessed her as able to make her needs known and she was her own decision-maker. She was susceptible to abuse by other residents and susceptible to abuse other residents.

Resident 2 lived in an assisted living facility. His medical diagnoses were post-traumatic stress disorder (PTSD) and intracranial injury. Resident 2's service plan indicated he received medication administration and safety checks three times daily. The nurse assessed him as able to make his needs known and he was his own decision-maker. He was susceptible to abuse by other residents and susceptible to abuse other residents.

Resident 1 and resident 2 moved to the facility together but lived in separate rooms across the hall from each other. According to staff members, resident 1 and resident 2 had a relationship, but resident 2 also had a new girlfriend which visibly upset resident 1.

Resident 1's progress note indicated a staff member noticed resident 1 had a reddish bruise on her forehead. Resident 1 said she fell but did not give details on what happened. The staff member notified the owner who completed an incident report and contacted the nurse to assess resident 1. The owner also offered to take resident 1 to the emergency room for assessment but resident 1 declined.

The owner said she had no report of resident 1 falling during the overnight shift. She said a male visitor visited resident 2 that night. Resident 2 said the visitor was his son. The visitor had not been to the facility before and was only known by a nickname. The owner said the visitor spent an hour in the bathroom and was "bothering the staff and clients" before she asked him to leave. Resident 2 refused to let the visitor leave for a few hours because he had a right to visitors. There was no information on what the visitor did to bother staff and residents and there were no complaints from other residents.

About one month later, police came to interview resident 1. The owner said she asked resident 1 what happened. Resident 1 said she lied to police and her doctor when she said she fell and bruised her head. Resident 1 said she initiated oral sex with the visitor to make resident 2 jealous. When she changed her mind the visitor threatened resident 1 with an unseen knife if she did not complete the act. She was not sure how she got the bruise to her head. Resident 1 said she was afraid of resident 2; he had once threatened to send gang members after her if

she ever put him in jail. The owner said she instructed staff to start 30-minute safety checks on resident 1 whenever resident 2 was present.

The clinic record indicated resident 1 told her provider she fell and bruised her head.

The police report indicated resident 2 reported the incident occurred a month earlier, which conflicted with the timing of the facility's staff report of a visitor and observation of a bruise to resident 1. Resident 1 said the visitor initiated oral sex with her. She was punched in the head either by resident 2 or the visitor. The facility staff requested trespassing orders against the visitor. The allegation was forwarded to the criminal investigation division to further investigate.

During an interview, the owner said resident 1 changed her story a few times about what happened with resident 2 and the visitor and when it happened. The owner was not aware of any assault incident reported to law enforcement, she was informed of the incident that occurred a month later. Only when police arrived did she learn of the alleged first assault. The owner said staff do hourly safety checks. They have to go into the room and ask if the resident is ok. Sometimes they cannot go into the room if the resident declines due to privacy, but if staff thinks there is a problem, they can enter the room anyway. The owner was not sure staff documented safety checks. The overnight staff member told her the only issue that night was loud music and he asked resident 2 to turn down the volume.

During an interview, the overnight staff person said he sent texts about loud music and safety checks. He said he was working and needed to end the call but agreed to a recorded interview the following morning. The next morning, he failed to answer the phone. He did not return voice mails and calls to reschedule the interview.

During an interview, another overnight staff member said there were really no safety checks or documentation of them for three of the four residents. Resident 1 and resident 2 were up all night watching TV or on their phones. She might check on them once a shift.

During an interview, the former nurse said she believed resident 1 fell because she had hip issues and used a wheeled walker, so she was unsteady on her feet. The nurse said she wondered if resident 2 had hit resident 1, but she had no proof any abuse happened and never saw resident 1 and resident 2 argue or fight. The nurse scheduled a doctor's appointment for resident 1 to get the bruise assessed, but resident 1 cancelled and then rescheduled the appointment. The nurse said staff did safety checks, but she did not know the policy or procedure for documenting them.

Resident 1 declined a recorded interview.

Resident 2 said he did not know anything about the incident and declined a recorded interview.

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:** No. Resident 1 and Resident 2 both declined interviews.

**Family/Responsible Party interviewed:** Not Applicable. Both resident 1 and resident 2 were their own decision makers.

**Alleged Perpetrator interviewed:** Not applicable.

**Action taken by facility:**

The facility reported the incident and called police after resident 1 changed her account of how she sustained the bruise. The facility attempted to have resident 1 examined by a medical provider. The facility requested no trespassing orders against the visitor. The facility initiated more frequent safety checks for resident 1. The owner notified case workers of the concern between resident 1 and resident 2.

**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

Columbia Heights Police Department

Anoka County Attorney

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>36754</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/14/2024</b>
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NAME OF PROVIDER OR SUPPLIER  <b>MIDWEST GROUP HOME LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4232 5TH STREET NE COLUMBIA HEIGHTS, MN 55421</b>
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0 000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>ASSISTED LIVING PROVIDER CORRECTION ORDER</p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation.</p> <p>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.</p> <p>INITIAL COMMENTS:</p> <p>HL367543779C/HL367543503M</p> <p>On August 14, 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 four residents receiving services under the provider's Assisted Living Care license.</p> <p>The following correction orders are issued for HL367543779C/HL367543503M, tag identification 1640 and 1650.</p>	0 000	<p>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.</p> <p>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.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p> <p>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.</p>	
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to	01640		

Minnesota Department of Health  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

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01640	<p>Continued From page 1</p> <p>(a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan.</p> <p>(b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities.</p> <p>(c) The facility must implement and provide all services required by the current service plan.</p> <p>(d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable.</p> <p>(e) Staff providing services must be informed of the current written service plan.</p> <p>This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to finalize a current written service plan no later than 14 calendar days after the date services are first provided, failed to have a system of documenting services of safety checks and failed to update the service plan with safety checks when they were changed in frequency, for two of two residents (R1 and R2) reviewed. This had the potential to affect all residents.</p> <p>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</p>	01640		

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01640	<p>Continued From page 2</p> <p>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).</p> <p>The findings include:</p> <p>Failure to Finalize a Service Plan within 14 Days R1 admitted to the licensee on February 14, 2024. R1's medical diagnoses included depression and post traumatic stress disorder (PTSD).</p> <p>R1 lacked a finalized current written service plan within 14 calendar days of her services starting.</p> <p>R1's service plan addendum, dated March 21, 2024, indicated R1 received medication administration, behavior management for agitation, aggression, repetitive behavior and self-injurious behavior. R1 received safety checks three times daily.</p> <p>R2 admitted to the licensee on February 14, 2024. R2's medical diagnoses included intracranial injury and PTSD.</p> <p>R2 lacked an finalized current written service plan within 14 calendar days of his services starting.</p> <p>R2's unsigned service plan addendum, dated July 1, 2024, indicated R1 received medication administration, behavior management for: agitation, aggression, repetitive behavior and self-injurious behavior. R1 received safety checks three times daily.</p> <p>An email sent by the MDH surveyor to OW-A on August 15, 2024 at 3:49 p.m. requested copies of the initial finalized current written service plans for</p>	01640		

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01640	<p>Continued From page 3</p> <p>R1 and R2. The MDH surveyor did not observe finalized written current service plans in R1's chart or R2's chart within 14 days of receiving services.</p> <p>An email from OW-A, dated August 22, 2024 at 1:1 p.m., indicated after reviewing records, the licensee did not have any service plans created earlier than July 2024 for R2. The email had two attachments of services plans: R1's service plan dated March 21, 2024 and R2's service plan dated July 1, 2024.</p> <p>During an interview on August 22, 2024 at 3:34 p.m., OW-A said R1 and R2 moved in to the licensee February 14, 224 and their services began right away. OW-A did not know the service plan was not part of the AL contract</p> <p>A policy titled Service Plans, dated July 15, 2024, indicated an individualized service plan is implemented for all residents beginning with the date assisted living services are first provided The service plan will be finalized no later than 14 days after the date home care services are first provided.</p> <p>Failure to Update Service Plan and Document Services R1's service plan addendum dated March 21, 2024, indicated R1 received medication administration, behavior management for agitation, aggression, repetitive behavior and self-injurious behavior. R1 received safety checks three times daily.</p> <p>R1's individual abuse prevention plan (IAPP) dated February 14, 2024, indicated R1 was able to report abuse, neglect or exploitation. R1 was susceptible to abuse from another individual,</p>	01640		

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01640	<p>Continued From page 4</p> <p>including other vulnerable adults and she was at risk of abusing other vulnerable adults. Staff members were instructed to call 911 if R1 was in danger.</p> <p>R2's unsigned service plan addendum dated July 1, 2024, indicated R2 received medication administration, behavior management for: agitation, aggression, repetitive behavior and self-injurious behavior. R2 received safety checks three times daily.</p> <p>R2's IAPP dated February 27, 2024, indicated he was able to report abuse, neglect and exploitation. R2 was susceptible to abuse from another individual including other vulnerable adults. R2 was at risk of abusing other vulnerable adults. Staff were instructed to call 911 if R2 was in danger.</p> <p>A resident incident report dated April 3, 2024, 3:30 a.m., indicated R1 had a self-reported fall. Unlicensed personnel (ULP)-E noticed R1 with a bruise lying on one of the resident's rooms. R1 was not crying or in any pain. R1 said she fell down and that this "is not a big deal."</p> <p>An incident report, completed by owner (OW)-A, dated April 3, 2024 at 8:05 a.m., indicated R1 had a bruise on her forehead and when asked what happened she stated she fell down and that she always falls down all the time. An ice pack was applied. OW-A offered to take R1 to see a doctor but she declined.</p> <p>A nursing note dated April 7, 2024, written by registered nurse (RN)-D, indicated R1's face was bruised, scratched and had a bump. The bruises were dark purple and extended below her eyes. R1 refused vitals, assessment, or a doctor's visit</p>	01640		

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01640	<p>Continued From page 5</p> <p>and told RN-D she fell. R1 said she felt safe at facility.</p> <p>An incident progress note dated May 14, 2024, written by OW-A indicated police came to the licensee and interviewed R1 about the April incident. OW-A spoke to R1 after police left. R1 said she did not fall that night, she initiated oral sex with the male visitor to make R2 jealous. She changed her mind after she unzipped his pants and the male visitor threatened her with an unseen knife if she did not finish the act. R1 said she lied to police about her bruise.</p> <p>A resident incident report dated May 17, 2024, at 2:03 p.m., indicated R1 called OW-A and said she was afraid of R2 because he used to be a gang member and threatened to send gang members after her. There were no witnesses to the threat. Staff would do safety checks every 30 minutes when R1 and R2 were together.</p> <p>R1's service plan was not updated to include safety checks every 30 minutes when with R2. R1's record lacked documentation of safety checks.</p> <p>R2's service plan was not created during the incident of April and May 2024. R2's service plan created July 1, 2024, lacked safety checks every 30 minutes when with R1. R2's record lacked documentation of safety checks.</p> <p>During an interview on August 14, 2024, at 11:30 a.m., OW-A said the nurse was responsible for assessments and interventions to keep the resident's safe, which can include safety checks every 30 minutes. OW-A said they used RTasks system to document services, but was not sure safety checks were documented.</p>	01640		

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01640	<p>Continued From page 6</p> <p>During an interview on August 14, 2024, at 1:10 p.m., ULP-B said she did not work that overnight shift when the R1 sustained the bruise. She heard there had been a male visitor who was a problem but did not have any more information. ULP-B said there are no regular safety checks for three of the four residents. She regularly checks on one resident because his blood glucose can drop at night, but R1 and R2 were usually awake all night watching TV or on their phones. She might check on them once during the shift.</p> <p>During an interview on August 20, 2024, at 1:12 p.m., former ULP-C said he did safety checks during the overnight shift. He said R1 and R2 played music too loud that night when the visitor was there and ULP-C asked them to turn the volume down. There were no other problems and ULP-C said R1 seemed very happy during the overnight shift.</p> <p>During an interview on August 21, 2024 at 12:05 p.m., former RN-D said unlicensed staff did safety checks on the residents but she did not know if they documented the checks.</p> <p>A policy titled Clinical Records, dated 2022, indicated the client clinical record would include: -documentation of services provided as identified in the service plan -documentation of communication/coordination pertinent to the resident's assisted living situation -other information needed to provide assisted living service.</p> <p>The licensee did not have a policy/procedure specific to safety checks.</p> <p>TIME PERIOD TO CORRECT: Seven (7) Days</p>	01640		

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01650 SS=E	<p>144G.70 Subd. 4 (f) Service plan, implementation and revisions to</p> <p>(f) The service plan must include:</p> <p>(1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences;</p> <p>(2) the identification of staff or categories of staff who will provide the services;</p> <p>(3) the schedule and methods of monitoring assessments of the resident;</p> <p>(4) the schedule and methods of monitoring staff providing services; and</p> <p>(5) a contingency plan that includes:</p> <p>(i) the action to be taken if the scheduled service cannot be provided;</p> <p>(ii) information and a method to contact the facility;</p> <p>(iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and</p> <p>(iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters.</p> <p>This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to ensure the service plan included the fees for services for two of two resident (R1 and R2) records reviewed.</p> <p>This practice resulted in a level two violation (a</p>	01650		

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01650	<p>Continued From page 8</p> <p>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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).</p> <p>The findings include:</p> <p>R1 admitted to the licensee on February 14, 2024. R1's medical diagnoses included depression and post traumatic stress disorder (PTSD).</p> <p>R1's service plan addendum dated March 21, 2024, lacked the fees for services. R1 received medication administration, behavior management for agitation, aggression, repetitive behavior and self-injurious behavior. R1 received safety checks three times daily.</p> <p>R2 admitted to the licensee on February 14, 2024. R2's medical diagnoses included intracranial injury and PTSD.</p> <p>R2's unsigned service plan addendum dated July 1, 2024, lacked fees for services. R2 received medication administration, behavior management for: agitation, aggression, repetitive behavior and self-injurious behavior. R2 received safety checks three times daily.</p> <p>During an interview on August 14, 2024 at 11:30 a.m., owner (OW)-A said service plans are part of the chart and part of the AL contract. There was a section for the services.</p>	01650		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>36754</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/14/2024</b>
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NAME OF PROVIDER OR SUPPLIER  <b>MIDWEST GROUP HOME LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4232 5TH STREET NE</b> <b>COLUMBIA HEIGHTS, MN 55421</b>
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(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
01650	<p>Continued From page 9</p> <p>An email sent by the MDH surveyor to OW-A on August 15, 2024, at 3:49 p.m. requested copies of the original service plans for R1 and R2, they were not observed in either R1 or R2's charts.</p> <p>An email with an attachment from OW-A to the MDH surveyor on August 19, 2024, at 1:15 p.m., indicated the service plans that were in the record was a printout by the nurse. The email indicated the attachment was the service plan they use for residents.</p> <p>The attachment was a screenshot of one page from the assisted living contract, "IV. Assisted Living Services, 2. Services, Service Plan and Amendment," which indicated a resident will have an attached addendum of their services to the service plan. There was no initial service plan addendum for R1 or R2 included in the email.</p> <p>A policy titled Service Plans, dated July 15, 2024, indicated an individualized service plan is implemented for all residents beginning with the date assisted living services are first provided. The service plan will include fees for services and the frequency of each service, according to the resident's current view or assessment preferences.</p> <p>TIME PERIOD TO CORRECT: Twenty-one (21) Days</p>	01650		