STATE LICENSING COMPLIANCE REPORT

Report #: HL37104003C **Date Concluded: August 1, 2022**

Name, Address, and County of Facility Investigated:
Greatercare Facilities
2087 Woodbridge Way
Woodbury, MN 55125

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Yolanda Dawson, 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
	37104	A. BUILDING: _____ B. WING _____	C 07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREATERCARE FACILITIES LLC	2087 WOODBRIDGE WAY WOODBURY, MN 55125

(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 Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, this correction order is 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: #HL37104003C On July 1, 2022 , the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction order is issued. At the time of the complaint investigation, there were 5 residents receiving services under the provider's Assisted Living license. The following correction order is ssued for #HL37104003C, tag identification 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.	
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 record review, the licensee failed to provide a written termination of housing and did not allow a resident to return to the facility after an emergency relocation when one of one resident (R1) posed an imminent safety risk to herself, other residents, and facility staff members and required hospitalization. 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 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 was admitted to the licensee on December 2, 2021, with diagnoses that included anxiety, attention deficit hyperactivity disorder (ADHD), major depression, autism spectrum disorder, and unspecified mood disorder and impulsivity. R1's care plan dated February 14, 2022, indicated R1	01070		

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01070	Continued From page 2 received services for wound care, one-to-one staffing, behavior monitoring, and safety checks. R1's incident report dated February 20, 2022, indicated R1 was assessed and took part in a crisis mental health assessment in the emergency department. R1 did not meet the criteria for inpatient placement. When the hospital attempted to discharge R1 back to the facility they refused to take her back due to self-injurious behaviors and concerns for resident and staff safety. Assisted Living Laws and Rules Statue 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. Review of email communication between case managers, the positive support specialist, social workers, the facility director, and the guardian, from February 14, 2022, to March 2, 2022, indicated all agreed that this facility was not the appropriate environment for R1 as they could not ensure her safety or the safety of staff members and other residents. The group was in the process of finding a suitable placement for R1 when she went to the hospital and everyone understood she was not returning to the facility. However, finding a suitable facility with space availability took a significant amount of time to find. During an interview on July 6, 2022, at 10:35 a.m., a case manager (CM) stated R1 had a history of aggressive behavior and assault. The CM stated there was continual email	01070		

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01070	Continued From page 3 communication with the facility regarding R1's behavior. The CM stated R1 could not return to the facility after her last hospitalization because they could not ensure the safety of R1 or staff members. The CM stated she was not provided written notice of R1's discharge or termination of housing. During an interview on July 6, 2022, at 12:34 p.m., a director stated R1 had three occurrences of self-injurious behavior in one day. On February 20, 2022, at 12:15 a.m., the resident was sent to the hospital and was discharged back to the facility at 4:00 a.m. At 11:30 a.m., the resident was sent back to the hospital a second time and returned to the facility at 3:30 p.m. at The third time on the same day, R1 was sent to a different hospital and was admitted after the facility did not allow her to return. The director stated R1 was cutting herself, biting her skin off, smearing blood everywhere, and spitting and fighting with staff members. R1 was assigned one-to-one supervision, however staff members were afraid for their safety. The director stated the facility's termination protocol was to initiate a pre-termination process, however, in this case, they did not have an opportunity to do that because of the safety issue for staff and other residents. The director stated R1 was not terminated, and the situation dictated that she could not return because R1 stated she did not want to live at this facility and continued to threaten to harm herself if she returned. The director stated the facility policy indicates a written notice is not needed for expedited termination and therefore only provided a discharge summary to the guardian. During an interview on August 1, 2022, at 3:53 p.m., the guardian stated R1 had a history of	01070		

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01070	Continued From page 4 serious self-harm and aggression towards others. The guardian stated R1 had a pattern of self-harm because she liked going to the hospital. However, R1 was able to turn her behaviors on and off and would be sweet and bubbly at the hospital. Then the hospital would say nothing is wrong with her and discharge her back to the facility where she would self-harm again. The guardian stated she has been blacklisted from care facilities in the metro area because of her serious behaviors. The guardian stated she received verbal notification from the facility that R1 could not return. The Guardian stated she was provided a discharge summary, however, did not receive written notice of termination of housing or services. A facility policy titled "Contract Termination" dated August 1, 2021, indicated the following: Termination for violation of assisted living contract. 3.The facility is not required to provide a resident with written notice of the ability to cure for a violation that threatens the health or safety of the resident or another individual in the facility, or for a violation that constitutes illegal conduct. Expedited termination. 1.A facility may initiate an expedited termination of housing or services if: a.The resident has engaged in conduct that substantially interferes with the rights, health, or safety of other residents b.The resident has engaged in conduct that substantially and intentionally interferes with the safety or physical health of facility staff, or c.The resident has committed an act listed in section 504B.171 that substantially interferes with the rights, health, or safety of other residents. 2.A facility may initiate an expedited termination	01070		

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01070	Continued From page 5 of services if: a.The resident has engaged in conduct that substantially interferes with the resident's health or safety b.The resident's assessed needs exceed the scope of services agreed upon in the assisted living contract and are not included in the services the facility disclosed in the Uniform Disclosure of Assisted Living Services and Amenities (UDALSA), or c.Extraordinary circumstances exist, causing the facility to be unable to provide the resident with the services disclosed in the uniform checklist that are necessary to meet the resident's needs. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01070		