

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL371266363M
Compliance #: HL371269524C

Date Concluded: November 21, 2024

Name, Address, and County of Licensee

Investigated:

St. John's Home Care LLC
10805 S Shore Drive
Medicine Lake, MN 55441
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Brooke Anderson, RN
Special Investigator

Finding: Substantiated, facility and individual responsibility

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 the resident when the facility failed to provide staff for the resident's 24/7 needs.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined neglect was substantiated. The facility and an individual, the facility owner, were responsible for the maltreatment. The owner also served as the licensed assisted living director (LALD) and registered nurse (RN) of the facility and was responsible for the daily operations, nurse management, and staffing of the facility. The facility was not continuously staffed, and care and services were not provided in accordance with the service plan for the first ten months that the resident resided at the facility.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted the resident's case worker. The investigation included review of the resident record, staff schedules, and related facility

policies and procedures. Also, the investigator observed interactions between staff and residents.

The resident resided in an assisted living facility. The resident's diagnoses included major depressive disorder, anxiety, post-traumatic stress disorder (PTSD), and psychotic disorder with delusions. The resident's assessment indicated the resident had anxiety, agitation, and self-injurious behavior. The resident's service plan included assistance with homemaking, shopping, meals, medication set-up and behavior monitoring for anxiety and verbal aggression three times per day.

Review of facility records included no documentation to support that the facility was staffed twenty-four hours per day or that services were provided to the resident for the first ten months that she resided at the facility.

Staffing schedules for the past ten months were requested but not provided by the facility.

The resident's medical record included no information about her admission to the facility. The resident's medical record included a service plan, but no documentation was provided to support that the services were provided by facility staff. The resident's medical record included no evidence of communication with the case manager or physician about concerns with providing services, the inability to provide services, or that services were not being provided as agreed upon per the service plan, for the first ten months of the resident's stay at the facility.

During an interview, the resident stated she moved into the facility approximately one year ago and the facility did not have staff available to provide supervision or care assistance. The resident stated she received "no services, not at all" and staff only started coming around more recently. The resident stated there were incidents throughout the year when she needed staff assistance, but none were available. The resident indicated she had a few falls and did not get her medication for months which put her in a "bad head space" and she needed to get a new psychiatrist. The resident stated her boyfriend was the one that helped her with cares, not facility staff.

During an interview, the facility owner acknowledged the resident had been living at the facility independently with her boyfriend and confirmed the facility was not staffed twenty-four hours per day, seven days per week, until last month. The facility owner stated she was confused about the licensure requirements but that the facility was now staffed 24 hours per day with her as the primary caregiver. The owner indicated that there was a medical record and documentation for the resident, but no additional documentation was provided to support that the resident received the services identified in the service plan agreement.

During an interview, the resident's case manager stated the resident needed staff supervision and support, but her boyfriend was the one who provided that support. The case manager stated a form was filled out by the facility owner that indicated what services the facility would

provide to the resident and the form determined the payment made to the facility. The case manager stated the facility was paid but none of the services were being provided as agreed upon, including the facility not being staffed twenty-four hours per day.

During an interview, a family member stated during his weekly visits at the facility he never saw staff on site.

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

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.

"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

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: Yes.

Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:

24-hour staffing was implemented.

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

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc:

The Office of Ombudsman for Long Term Care

The Office of Ombudsman for Mental Health and Developmental Disabilities

Hennepin County Attorney

Medicine Lake City Attorney

Medicine Lake Police Department

Minnesota Board of Executives for Long Term Services and Support

Minnesota Board of Nursing

REQUEST FOR RECONSIDERATION RECEIVED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37126	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/23/2024
NAME OF PROVIDER OR SUPPLIER ST JOHN HOME CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 10805 SOUTH SHORE DRIVE MEDICINE LAKE, MN 55441		
(X4) ID PREFIX TAG 0 000	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG 0 000	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
	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: #HL371269524C/#HL371266363M #HL371267821C On October 23, 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 was 1 resident receiving services under the provider's Assisted Living license. The following correction orders are issued for ##HL371269524C/#HL371266363M, tag identification 490, 730, 2310, 2360.		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

Minnesota Department of Health

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0 490	Continued From page 1	0 490			
0 490 SS=F	144G.41 Subd 1 (13) (ii)-(vii) Minimum requirements (iv) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance; (v) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance; (vi) provide culturally sensitive programs; and (vii) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large; and This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the licensee failed to provide reasonable assistance with arranging for transportation or access to the community or community resources, and failed to have a daily program of social and recreational activities based on individual interests and mental and psychosocial needs for one of one resident (R1) 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	0 490			

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0 490	Continued From page 2 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 medical record did not include an admission date. R1's August 8, 2023, service plan agreement signed by a facility staff member, R1, and R1's family, indicated R1 received the following services: assistance with dressing two times per day, daily grooming assistance, daily bathing assistance, verbal and visual medication reminders two times per day, medication administration two times per day, laundry three times per week, anxiety management three times per day, and verbal aggression management three times per day. A customized living rate worksheet dated April 9, 2024, filled out by the owner/licensed assisted living director/registered nurse (LALD/RN)-A indicated the licensee provided 24 hour customized living services and the following services to R1: homemaking, shopping, assistance with transportation, assistance with appointment making, meals, 1:1 socialization, activities and group socialization, daily outings with staff; daily transportation; medication refills, medication reminders, redirection, behavior management for anxiety, agitation, self-injurious behavior including substance use, verbal aggression, and repetitive behaviors. The support plan also indicated staff would assist in ensuring R1 was not alone for too long, were to redirect R1 so they did not isolate, and encourage participation in activities and conversation with	0 490	REQUEST FOR RECONSIDERATION RECEIVED		

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0 490	Continued From page 3 staff. R1's support plan completed by R1's case manager indicated R1 received 24 hour customized living services from the licensee. The support plan indicated the licensee received a daily rate for services provided to R1 at \$476.23; a monthly rate of \$14,485.33. R1's areas of need included communication, eating and meal preparation, health interventions, household management, meaningful activities, personal cares, psychosocial health, and self-preservation. Support instructions indicated the licensee would provide 24 hour customized living services with overnight staffing as needed and the licensee would follow R1's behavior support plan. The support plan further indicated all doctor orders, medication administration, and follow-up appointments will be performed by staff. Staff will document all medication use, prescribed treatments, and monitor for side effects. The support plan included a daily rate for mental health management of \$247.86 for managing anxiety, repetitive behavior, agitation, self-injurious behavior, verbal aggression and meeting other cognitive/mental health needs. The notes section indicated staff would manage the other mental health need by encouraging R1 to attend activities and ensure R1 is not alone for too long. Staff will redirect R1 from being isolated and engage in conversation. The support plan was signed by the licensee on April 4, 2024. The signature line included that the provider reviewed the plan, acknowledged the supports and services in the plan and agreed to provide the supports and services as outlined in the plan. R1's medical record included no documentation of services provided, behavior monitoring, transportation provided, outings in the	0 490	REQUEST FOR RECONSIDERATION RECEIVED		

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0 490	Continued From page 4 community, 1:1 socialization, activities, or additional pertinent medical information or documentation for R1 from October 2023 through October 2024, as indicated to be provided by facility staff per R1's service plan and customized living worksheet. R1's record included no evidence of activities completed by licensee staff and no evidence of the service plan outings, socialization, redirection, or activities completed by licensee staff at anytime during R1's stay at the facility. During observation at the facility on October 23, 2024, there was no evidence of activities being completed at the facility. There was no activities calendar posted at the facility. No activity calendar was provided by the licensee. During an interview with the owner/LALD/RN on October 23, 2024 at 10:27 a.m. the owner/LALD/RN confirmed the building was licensed as an assisted living facility however, stated that prior to a recent department of health survey, she was not aware that she had to provide 24 hour staffing, 7 days per week at the facility. The owner/LALD/RN stated she was confused by the requirements of an assisted living licensed by MDH versus the DHS regulations of another facility type. The owner/LALD/RN confirmed that staffing was not provided 24/7 over the last year that R1 resided at the facility, despite the building being licensed as an assisted living facility. The owner/LALD/RN stated that R1 tried to fight with staff and if she was yelling or getting aggressive, she just left her alone and told staff that they could leave. Staffing schedules for September 2024 and	0 490			

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0 490	Continued From page 5 October 2024 were provided. A review of the schedules indicated the owner/LALD/RN worked from 3:00 p.m. - 7:30 a.m. 23 days out of 30 days in September 2024. The October 2024 schedule indicated the owner/LALD/RN worked 3:00 p.m. - 7:30 a.m. 28 days out of 31 days. A schedule provided for November 1- 23, 2024 indicated the owner/LALD/RN was scheduled to work all 23 days from 3:00 p.m. - 7:30 a.m. During an interview with R1's case manager (CM)-B on November 1, 2024, at 1:34 p.m., CM-B indicated R1 began receiving services from the licensee on August 8, 2023 at a different location owned by the licensee. R1 moved to the current facility location in October of 2023, but CM-B was not informed of the move until March 2024. CM-B indicated the facility filled out a customized living worksheet indicating what services they agreed to provide to R1 and CM-B was responsible for adding this to R1's support plan to calculate the daily rate for the services that the facility was to provide to R1. CM-B stated that based on what the facility was billing for the daily rate there should be staff with R1 but from what I have heard, staff have been not present. R1 told CM-B that they could count on one hand how many times staff have come to the facility. After the visit with MDH, they [the facility] has been trying to have a staff member there all of the time. It sounds like that staff member is primarily the owner, she is there almost all the time. Prior to the MDH visit, staff weren ' t ' t there hardly at all. CM-B stated that R1 is getting informal support from her boyfriend and he is completing a lot of the support and assistance that she needs; a lot of the things she needs help with her boyfriend has been helping with. During an interview with R1 on November 1,	0 490			

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0 490	Continued From page 6 2024, at 2:10 p.m., R1 confirmed she started receiving care from the licensee on August 8, 2023 at a different location and moved to this location on October 4, 2023. R1 indicated she lived alone at the facility with her boyfriend. R1 stated her boyfriend left after a visit with her at the previous facility and the owner noticed she was sad and said he could move in; so he did. After a disagreement with another resident at the facility, the owner moved R1 and her boyfriend to this location. R1 stated prior to the licensee's most recent survey in September (last month), she received "no services, not at all" and after the survey she [the owner] started coming around more because she didn't want you guys to see I live her by myself. She [the owner] moved into the basement. The only services have nothing to do with me. She [the owner] has staff come from 7 am to 1:30 pm and then her and her son take over the shifts. They don't talk to me, they don't make eye contact with me. They come here and clean whatever dishes are in the sink but other than that, they don ' t do anything else. They clean their own mop rags. It is sorta like she is trying to make it seem like she is busy and she is not. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) Days.	0 490	REQUEST FOR RECONSIDERATION RECEIVED		
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number;	0 730			

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0 730	Continued From page 7 (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this	0 730	REQUEST FOR RECONSIDERATION RECEIVED		

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0 730	Continued From page 8 chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the licensee failed to ensure resident record included the required content and relevant health information and documentation for one of one resident (R1) 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 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 included: R1's medical record did not include an admission date or diagnoses. R1's August 8, 2023, service plan agreement signed by a facility staff member, R1, and R1's family, indicated R1 received the following services: assistance with dressing two times per day, daily grooming assistance, daily bathing assistance, verbal and visual medication reminders two times per day, medication administration two times per day, laundry three times per week, anxiety management three times per day, and verbal aggression management three times per day. R1's outside agency case manager notes	0 730			

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0 730	Continued From page 9 indicated R1 moved to the facility on October 4, 2023. R1 initially admitted to another facility owned by the licensee on August 8, 2023, and began receiving services on August 8, 2023. Upon R1's move to this facility on October 4th, 2023, services were continued per the August 8, 2023 signed service agreement. R1's medical record did not identify R1's admission to the previous facility or transfer and admission to the current facility owned by the licensee. R1's initial individualized medication management plan dated August 8, 2023, updated July 30, 2024, indicated R1 was independent with medication administration and medication set-up. The medication plan indicated the resident and facility nurse were responsible for monitoring supplies and ordering refills on a timely basis. The medication management plan further indicated that unlicensed personnel (ULP) could contact the nurse with questions and documentation of medications, verifications of administration, and monitoring of adverse effects would be indicated on the medication administration record (MAR). R1's medical record lacked physician's orders for medications prescribed to R1. R1's medical record lacked MARs for October 2023 through August 2024. R1's medical record included no evidence of medication set-up, administration, medication reminders, ordering of supplies or medication refills, adverse effect monitoring provided by staff from October 2023 through August 2024. R1's MAR for September 2024 and October 2024	0 730	REQUEST FOR RECONSIDERATION RECEIVED		

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0 730	Continued From page 10 indicated R1 self-administered her medications. R1's medical record included no evidence of physician's orders for the medications identified on the September and October 2024 MAR. A customized living rate worksheet dated April 9, 2024, filled out by the owner/licensed assisted living director/registered nurse (LALD/RN)-A indicated the licensee provided 24 hour customized living services and the following services to R1: homemaking, shopping, assistance with transportation, assistance with appointment making, meals, 1:1 socialization, activities and group socialization, daily outings with staff; daily transportation; medication refills, medication reminders, redirection, behavior management for anxiety, agitation, self-injurious behavior including substance use, verbal aggression, and repetitive behaviors. The support plan also indicated staff would assist in ensuring R1 was not alone for too long, redirect so R1 did not isolate, and encourage participation in activities and conversation with staff. R1's medical record did not include documentation of services provided as identified in the service plan. R1's individual abuse prevention plan (IAPP) dated November 4, 2023, with updates on February 4, 2024, May 4, 2024, July 30, 2024, and indicated R1 was not susceptible to abuse by others, was not a risk to abuse others, and was not at risk for self-abuse. The IAPP did not include information identified in R1's customized living rate worksheet, including the risk of self-injurious behavior, agitation, or aggression, or substance use. R1's IAPP also did not include the information from R1's service plan of behavior monitoring for verbal aggression or anxiety.	0 730			

Minnesota Department of Health

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0 730	Continued From page 11 R1's support plan completed by R1's case manager indicated R1 received 24 hour customized living services from the licensee. The support plan indicated the licensee received a daily rate for services provided to R1 at \$476.23; a monthly rate of \$14,485.33. R1's areas of need included communication, eating and meal preparation, health interventions, household management, meaningful activities, personal cares, psychosocial health, and self-preservation. Support instructions indicated the licensee would provide 24 hour customized living services with overnight staffing as needed and the licensee would follow R1's behavior support plan. The support plan further indicated all doctor orders, medication administration, and follow-up appointments will be performed by staff. Staff will document all medication use, prescribed treatments, and monitor for side effects. The support plan included a daily rate for mental health management of \$247.86 for managing anxiety, repetitive behavior, agitation, self-injurious behavior, verbal aggression and meeting other cognitive/mental health needs. The notes section indicated staff would manage the other mental health need by encouraging R1 to attend activities and ensure R1 is not alone for too long. Staff will redirect R1 from being isolated and engage in conversation. The support plan was signed by the licensee on April 4, 2024. The signature line included that the provider reviewed the plan, acknowledged the supports and services in the plan and agreed to provide the supports and services as outlined in the plan. R1's medical record included no documentation of services provided, behavior monitoring, transportation provided, outings in the community, 1:1 socialization, activities, or	0 730	REQUEST FOR RECONSIDERATION RECEIVED		

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0 730	Continued From page 12 additional pertinent medical information or documentation for R1 from October 2023 through October 2024, as indicated to be provided by facility staff per R1's service plan and customized living worksheet. R1's medical record included no evidence of communication with R1's case manager about concerns with providing R1 services, the inability to provide services to R1, or that services were not being provided as agreed upon per R1's service plan or support plan. R1's provided progress notes indicated the dates of the notes included ranged from January 1, 2024 - October 23, 2024; however, progress note documentation was only available from August 30, 2024 through October 22, 2024. No progress notes were documented prior to August 30, 2024. During an interview with the owner/LALD/RN on October 23, 2024 at 10:27 a.m. the owner/LALD/RN confirmed the building was licensed as an assisted living facility however, stated that prior to a recent department of health survey, she was not aware that she had to provide 24 hour staffing, 7 days per week at the facility. The owner/LALD/RN stated she was confused by the requirements of an assisted living licensed by MDH versus the DHS regulations of another facility type. The owner/LALD/RN confirmed that staffing was not provided 24/7 over the last year that R1 resided at the facility, despite the building being licensed as an assisted living facility. The owner/LALD/RN indicated she had a medical record for R1 with the required information but no additional documentation was provided during the onsite visit or during later requests for documentation.	0 730	REQUEST FOR RECONSIDERATION RECEIVED		

Minnesota Department of Health

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0 730	Continued From page 13 No further information was provided. Time Period for Correction: Twenty-One (21) Days.	0 730			
02310 SS=G	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure appropriate care and services were provided based on the resident's needs and according to an up-to-date service plan and accepted health care standards for one of one residents (R1) when the building was not staffed as required 24 hours per day, 7 days per week and services were not provided in accordance with R1's signed service plan agreement for approximately ten months that the resident resided at the facility. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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:	02310			

Minnesota Department of Health

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02310	Continued From page 14 R1's medical record did not include an admission date. R1's service plan agreement dated August 8, 2023, was signed by a facility staff member, R1, and R1's family indicated R1 received the following services: assistance with dressing two times per day, daily grooming assistance, daily bathing assistance, verbal and visual medication reminders two times per day, medication administration two times per day, laundry three times per week, anxiety management three times per day, and verbal aggression management three times per day. R1's outside agency case manager notes indicated R1 moved to the facility on October 4, 2023. R1 initially admitted to another facility owned by the licensee on August 8, 2023 and began receiving services on August 8, 2023. Upon R1's move to this facility on October 4th, 2023, services were continued per the August 8, 2023 signed service agreement. R1's medical record did not identify R1's admission to the previous facility or transfer and admission to the current facility owned by the licensee. R1's medical record did not include a discharge summary detailing R1's discharge from the previous facility to the current facility. R1's initial individualized medication management plan dated August 8, 2023, updated July 30, 2024, indicated R1 was independent with medication administration and medication set-up. The medication plan indicated the resident and facility nurse were responsible for monitoring supplies and ordering refills on a timely basis. The medication management plan further	02310	REQUEST FOR RECONSIDERATION RECEIVED		

Minnesota Department of Health

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02310	Continued From page 15 indicated that unlicensed personnel (ULP) could contact the nurse with questions and documentation of medications, verifications of administration, and monitoring of adverse effects would be indicated on the medication administration record (MAR). R1's medical record lacked MARs for October 2023 through August 2024. R1's medical record included no evidence of medication set-up, administration, medication reminders, ordering of supplies or medication refills, adverse effect monitoring provided by staff from October 2023 through August 2024. R1's MAR for September 2024 and October 2024 indicated R1 self-administered her medications. R1's medical record included no evidence of physician's orders for the medications identified on the September and October 2024 MAR. A customized living rate worksheet dated April 9, 2024, filled out by the owner/licensed assisted living director/registered nurse (LALD/RN)-A indicated the licensee provided 24 hour customized living services and the following services to R1: homemaking, shopping, assistance with transportation, assistance with appointment making, meals, 1:1 socialization, activities and group socialization, daily outings with staff; daily transportation; medication refills, medication reminders, redirection, behavior management for anxiety, agitation, self-injurious behavior including substance use, verbal aggression, and repetitive behaviors. The support plan also indicated staff would assist in ensuring R1 was not alone for too long, redirect so R1 did not isolate, and encourage participation in activities and conversation with staff.	02310	REQUEST FOR RECONSIDERATION RECEIVED		

Minnesota Department of Health

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02310	Continued From page 16 R1's individual abuse prevention plan (IAPP) dated November 4, 2023, with updates on February 4, 2024, May 4, 2024, July 30, 2024, and indicated R1 was not susceptible to abuse by others, was not a risk to abuse others, and was not at risk for self-abuse. The IAPP did not include information identified in R1's customized living rate worksheet, including the risk of self-injurious behavior, agitation, or aggression, or substance use. R1's IAPP also did not include the information from R1's service plan of behavior monitoring for verbal aggression or anxiety. R1's support plan completed by R1's case manager indicated R1 received 24 hour customized living services from the licensee. The support plan indicated the licensee received a daily rate for services provided to R1 at \$476.23; a monthly rate of \$14,485.33. R1's areas of need included communication, eating and meal preparation, health interventions, household management, meaningful activities, personal cares, psychosocial health, and self-preservation. Support instructions indicated the licensee would provide 24 hour customized living services with overnight staffing as needed and the licensee would follow R1's behavior support plan. The support plan further indicated all doctor orders, medication administration, and follow-up appointments will be performed by staff. Staff will document all medication use, prescribed treatments, and monitor for side effects. The support plan included a daily rate for mental health management of \$247.86 for managing anxiety, repetitive behavior, agitation, self-injurious behavior, verbal aggression and meeting other cognitive/mental health needs. The notes section indicated staff would manage the other mental health need by encouraging R1 to attend activities and ensure R1 is not alone for	02310			

Minnesota Department of Health

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02310	Continued From page 17 too long. Staff will redirect R1 from being isolated and engage in conversation. The support plan was signed by the licensee on April 4, 2024. The signature line included that the provider reviewed the plan, acknowledged the supports and services in the plan and agreed to provide the supports and services as outlined in the plan. R1's medical record included no documentation of services provided, behavior monitoring, transportation provided, outings in the community, 1:1 socialization, activities, or additional pertinent medical information or documentation for R1 from October 2023 through October 2024, as indicated to be provided by facility staff per R1's service plan and customized living worksheet. R1's medical record included no evidence of communication with R1's case manager about concerns with providing R1 services, the inability to provide services to R1, or that services were not being provided as agreed upon per R1's service plan or support plan. R1's provided progress notes indicated the dates of the notes included ranged from January 1, 2024 - October 23, 2024; however, progress note documentation was only available from August 30, 2024 through October 22, 2024. No progress notes were documented prior to August 30, 2024. During an interview with the owner/LALD/RN on October 23, 2024 at 10:27 a.m. the owner/LALD/RN confirmed the building was licensed as an assisted living facility; however, stated that prior to a recent department of health survey, she was not aware that she had to provide 24 hour staffing, 7 days per week at the facility. The owner/LALD/RN stated she was	02310			

Minnesota Department of Health

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02310	Continued From page 18 confused by the requirements of an assisted living licensed by MDH versus the DHS regulations of another facility type. The owner/LALD/RN confirmed that staffing was not provided 24/7 over the last year that R1 resided at the facility, despite the building being licensed as an assisted living facility. The owner/LALD/RN stated that R1 tried to fight with staff and if she was yelling or getting aggressive, I just leave her and tell staff that they can go. Staffing schedules for September 2024 and October 2024 were provided. A review of the schedules indicated the owner/LALD/RN worked from 3:00 p.m. - 7:30 a.m. 23 days out of 30 days in September 2024. The October 2024 schedule indicated the owner/LALD/RN worked 3:00 p.m. - 7:30 a.m. 28 days out of 31 days. A schedule provided for November 1- 23, 2024 indicated the owner/LALD/RN was scheduled to work all 23 days from 3:00 p.m. - 7:30 a.m. No staffing schedules were provided prior to September 2024. An email request was sent to the owner/LALD/RN asking if staffing schedules could be provided from prior to September 2024 and the owner/LALD/RN replied "There is, but I can't find it. Thank you." No additional staffing schedules were provided. No additional documentation was provided to indicate services were provided as indicated and agreed upon based on the licensee completed customized living worksheet or R1's customized service support plan (CSSP). An October 4th 2024 meeting note regarding R1 was provided by the licensee. The note indicated that the department of health completed a survey and the licensee was told she had to provide 24	02310			

Minnesota Department of Health

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02310	Continued From page 19 hour staffing even if for just one person. The note further indicated since the licensee was licensed as an assisted living that 24 hour staffing was required and the amount paid to the licensee daily cannot cover 1:1 staffing 24/7. The note detailed additional concerns with R1 and R1's actions and living arrangements in the facility. The note concluded with concerns that R1 could not continue living at the facility and would be better fit to live in an independent apartment. An October 18th 2024 meeting note regarding R1 was provided by the licensee. The note indicated that R1 was complaining that staff do not do anything for her. The note indicated the facility was giving her medications, but R1 took the medications and hid them so they were now doing reminders. The note further indicated that R1 smoked marijuana in the house constantly and the house smelled of marijuana. The note went on to detail additional concerns with R1's behavior and conduct at the facility and indicated R1 could not remain in the facility as the owner could not afford it and R1 did not need twenty-four hour staffing and that R1 should reside at an apartment until other placement was found. During an interview with R1's case manager (CM)-B on November 1, 2024, at 1:34 p.m., CM-B indicated R1 began receiving services from the licensee on August 8, 2023 at a different location owned by the licensee. R1 moved to the current facility location in October of 2023 but CM-B was not informed of the move until March 2024. CM-B indicated the facility filled out a customized living worksheet indicating what services they agreed to provide to R1 and CM-B was responsible for adding this to R1's support plan to calculate the daily rate for the services	02310			

Minnesota Department of Health

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02310	Continued From page 20 that the facility indicated they were to provide to R1. Based on what the facility was billing for the daily rate there should be staff with R1 a little more than 19 hours per day. In any customized living setting, that isn't realistic it is usually an average. From what I have heard from R1, staff have been not present. R1 has said she could count on one hand how many times staff have come to the facility, prior to MDH's visit this summer. After the visit with MDH, they [the facility] has been trying to have a staff member there all of the time. It sounds like that staff member is primarily the owner, she is there almost all the time. Prior to the MDH visit, staff weren ' t there hardly at all. R1 is getting informal support from her boyfriend and he is completing a lot of the support and assistance that she needs; a lot of the things she needs help with her boyfriend has been helping with. In April of this year, the owner came to the house with other people and the people were waiting in the driveway in the car. One of them grabbed R1's chest. R1 immediately went in and told the owner who told R1 that she shouldn ' t have gotten that close to him and shouldn ' t ' t have been by him and then she left. The owner left and there were no staff there. R1 has a history of sexual assault and PTSD and could have had a mental health decline following an event like that. R1 could have used support following that time and it wasn ' t available to her with no staff in the facility. Since MDH's visit, it seems that they have been trying to discharge R1 due to the noticed lack of compliance. R1 feels like she is being retaliated against and that they are looking for reasons to get her out of there. She [R1] feels that way and I feel that way. I have been working on finding alternative placement. CM-B was provided pre-termination meeting notices from the licensee which were meeting notes from October 4th and	02310			

Minnesota Department of Health

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02310	Continued From page 21 October 18th provided by the licensee. The licensee indicated she planned to terminate R1's services and could not continue providing services and that the facility was not appropriate placement for R1. The meeting notes were provided as pre-termination notices but no official termination notice has been submitted. During an interview with R1 on November 1, 2024, at 2:10 p.m., R1 confirmed she started receiving care from the licensee on August 8, 2023 at a different location and moved to this location on October 4, 2023. R1 indicated she lived alone at the facility with her boyfriend. R1 stated after her boyfriend left after a visit with her at the previous facility, the owner noticed she was sad and said he could move in. After a disagreement with another resident at the facility, the owner moved R1 and her boyfriend to this location. R1 stated prior to the licensee's most recent survey in September (last month) she received "no services, not at all" and after the survey she [the owner] started coming around more because she didn't want you guys to see I live her by myself. She [the owner] moved into the basement. The only services have nothing to do with me. She [the owner] has staff come from 7 am to 1:30 pm and then her and her son take over the shifts. They don't talk to me, they don ' t make eye contact with me. They come here and clean whatever dishes are in the sink but other than that, they don ' t do anything else. They clean their own mop rags. It is sorta like she is trying to make it seem like she is busy and she is not. I was getting my medications up until April and they quit dropping them off after that and it just stopped. I had to find a different psychiatrist but I didn't get meds again until late August. I would like if staff were here all the time and there have been a few times when I fell or stumbled but	02310			

Minnesota Department of Health

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02310	Continued From page 22 my boyfriend was here. He would calm me down and I wasn't in my right mind to be doing anything near a stove because I wasn't getting my meds. So, I would have liked staff to be here. There was another time when [the owner] and another staff came and helped her with the ceiling. I walked outside and I went to grab the mail and I saw [another resident] was there. He used to live at [the other facility] and I walked to the mailbox and walked back and he rolled down the window and said "I know you," and I started to talk to him and he reached out and grabbed my breast. I went in the house and told [the owner] and she said, "Why did you go over there? Why did you go near him?" I went to tell [my boyfriend] but she [the owner] didn ' t ' t file anything. There were no staff here at that time and I had nobody to talk to after that incident occurred. There have been plenty of times I have complained to [the owner] and requested staff. I am afraid of retaliation and since MDH came in September, I have been getting retaliation. Retaliation in the way that the only thing that she [the owner] knows that would bother me are my plants, since I have been living here I have accumulated a lot of things and I have gotten a lot of plants and she moved them and pushed them up against the window. I told her not to push them up against my windows. All the plants would be moved; to the point that I put a camera behind my plants and when she was moving my plants you could see her breaking my succulent leaf off. She [the owner] ignores me and tries to make me react and I will get mad but I am not verbally aggressive like she said and I have never slapped anyone like she has said. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) Days.	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37126	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/23/2024
NAME OF PROVIDER OR SUPPLIER ST JOHN HOME CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 10805 SOUTH SHORE DRIVE MEDICINE LAKE, MN 55441			
(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
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident(s) reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility and an individual were responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360			

REQUEST FOR RECONSIDERATION RECEIVED