STATE LICENSING COMPLIANCE REPORT

Report #: HL265337129C

Date Concluded: May 3, 2024

Name, Address, and County of Facility Investigated:
Senior Class Community LLC
4451 East Woodman Street
Pequot Lakes, MN 56472
Crow Wing County

Facility Type: Assisted Living Facility with Dementia Care (ALFDC)

Evaluator's Name: Barbara Axness, 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
	26533	A. BUILDING: _____ B. WING _____	C 04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENIOR CLASS COMMUNITY LLC	4451 EAST WOODMAN STREET PEQUOT LAKES, MN 56472

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL265337129C On April 10, 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 14 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for #HL265337129C, tag identification 0250, 1060, 1070.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. 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 surveyors' 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 subd. 1, 2, and 3.	
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a	0 250		

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0 250	Continued From page 1 result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under	0 250		

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0 250	Continued From page 2 section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to fully cooperate with an inspection, survey, or investigation by the department. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On April 10, 2024, at 10:30 a.m., the investigator called the facility to initate a complaint investigation. The investigator identified herself to the staff member answering the phone and advised a complaint investigation was being initiated and asked to speak with the licensed	0 250		

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0 250	Continued From page 3 assisted living director or clinical nurse supervisor. The staff member stated she would transfer the call to chief executive officer (CEO)-A and wrote down a call back number for the investigator in case the call got disconnected. CEO-A answered the call and the investigator provided information on what the complaint investigation was about. The investigator told CEO-A an email would be sent in a few minutes with a list of documents to be sent today that needed to be reviewed. CEO-A confirmed her email address. On April 10, 2024, at 10:37 a.m., the investigator sent CEO-A an email requesting records for R1, some policies, and general information. The email included "Please have all information sent by end of day today, April 10th, by 4:30 p.m. Please let me know if you have any questions. Thank you!" On April 10, 2024, at 4:55 p.m., the investigator emailed CEO-A again writing, "I haven't heard anything back from you or received any information so just wanted to confirm you were not submitting any information for the investigation." On April 11, 2024, at 5:49 a.m., CEO-A replied with some of the requested documentation. The investigator wrote back advising CEO-A that the documents provided were submitted after the time they were requested by. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250		

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01060	Continued From page 4	01060		
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 and the Office of Ombudsman for Mental Health and Developmental Disabilities; (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 (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not	01060		

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01060	Continued From page 5 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.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide written notice with required content to the resident, legal representative, and designated representative 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 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 diagnoses included early onset Alzheimer's dementia without behavioral disturbance, bilateral hearing loss, and depression. R1's service plan dated October 10, 2023, indicated the resident received assistance with dressing, grooming, bathing, escorts, medication administration, and behavior management. R1's most recent assessment dated November 1, 2023, indicated the resident "had potential for agitation and combativeness as should always have at least two person assist." At least two staff were required due to "safety concerns."	01060		

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01060	Continued From page 6 R1's progress notes contained the following entries: -November 3, 2023, clinical nurse supervisor (CNS)-C informed the resident's wife about the resident's behaviors the prior night which included "assaulting staff, pulled fire alarm, and assaulted RN writer while trying to pass medications this AM...[licensed assisted living director (LALD)-B] was notified of resident behaviors this AM. She then notified this writer that resident needs to be sent to the ER ASAP given the dangerous behaviors." The resident's wife brought the resident to the emergency room for further evaluation. -November 4, 2023, chief executive officer (CEO)-A wrote that LALD-B spoke with the hospital and was informed that "resident will not be returning to us, [R1's wife] decided. Will follow up with [R1's wife] for confirmation." -November 6, 2023, CNS-C documented the resident's wife was at the facility moving the resident's belongings out. Documentation indicated R1's wife asked "if the 30 day notice was from Friday, 11/3 as was told "she cannot bring resident back unless she would stay with resident. Advise writer cannot confirm this and would need to reach out to [CEO-A] or [LALD-B] regarding the billing." Hospital records indicated the resident admitted on November 3, 2023, and had been a resident at "senior class care but had behavioral issues there. Was recently discharged from [acute care medical facility] to senior class care and within 48 hours he was brought back to the nursing home because of behavioral issues. While in the hospital he has not had behavioral problems..." The resident spent three days in the hospital waiting for alternative placement.	01060		

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01060	Continued From page 7 Hospital records contained a progress note dated November 3, 2023, at 11:02 a.m., which indicated, "Spoke with [clinical nurse supervisor (CNS)-C] at Senior Class Care and she stated they will be sending this patient in and they will not be taking him back as their director told them he was too much for them there and that there (sic) too many vulnerable residents that live there. She was assured that we would assess the patient and see what we could do to help, but you can't call stating that you wouldn't be taking the patient back again...She became angry with this writer and said the ED (emergency department) is an example of insanity and that we are just trying to avoid doing our job and hung up on this writer." Hospital social services documented they received a call back from CNS-C at 2:04 p.m., "asking for an update on the referral...she then advised us to tell the patient's wife to take the patient out of this ED and take him to the ED at [another hospital] so the patient would have priority for the bed [at the other hospital]. She was asked to repeat what she just said to make sure I heard it correctly. She repeated to advise the patient's wife to take the patient from this ED and take him to [another hospital] so he would be in their ED and have priority for the bed in [another city] She was told that we would not be telling the wife to take the patient out of this ED to be brought to [other city] hospital. [CNS-C] then stated she would call the patient's wife herself to give her that information. A progress note entered at 2:10 p.m., indicated R1's wife "came out of the patient's room about 2:10 p.m. with her cell phone on speaker phone. She identified she was speaking with [CNS-C] at Senior Class Care. [R1's wife] stood at the nurses desk in the ED so we would hear the conversation. [R1's wife] was told to take the patient to the [other city] hospital	01060		

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01060	Continued From page 8 to their ED so he would have priority for the bed at [other city] [R1's wife] said back to [CNS-C] several times that she would not be taking the patient out of this ED and bringing him to the [other city] hospital. [CNS-C] tried to explain that the patient needs this and she didn't want them to lose the bed there. [R1's wife] ended the conversation that she would not take him out of the ED as there was no guarantee what would happen then." After R1's wife ended the call with CNS-C, she expressed concern about bringing the resident back to the facility and how they might treat him if he returned. Hospital records indicated another discharge planner received an email "from the director at Senior Class Care stating the patient could return there but [R1's wife] would have to stay there with the patient until something else is figured out." R1's record did not include a written notice that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the OOLTC and the Office of Ombudsman for Mental Health and Developmental Disabilities; - 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 - 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. On April 11, 2024, at 5:49 a.m., CEO-A wrote in	01060		

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01060	Continued From page 9 an email, "...[R1] was not terminated by Senior Class Community as [licensed assisted living director (LALD-B] called discharge planners on November 4th, 2023, to get an update on resident's discharge date and time. [LALD-B] was informed that resident will not be returning to us, spouses' decision." On April 11, 2024, at 11:50 a.m., LALD-B stated they usually send in an emergency relocation notice but was not sure if one was completed in this situation. On April 11, 2024, at 1:30 p.m., R1's wife stated she was under the impression the facility couldn't care for the resident and they were giving her notice to move out. The licensee's Emergency Relocation policy revised August 1, 2023, indicated the licensee 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. In the event of an emergency relocation, Senior Class Community, LLC would provide a written notice that contains, at a minimum: The reason for the relocation, the 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 for Long-Term Care and Office of Ombudsman for Mental Health and Developmental Disabilities, 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 a statement that, if the facility refuses to provide housing or	01060		

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01060	Continued From page 10 services after a relocation, the resident has the right to appeal. The facility would provide contact information for the agency to which the resident may submit an appeal. The notice required would be delivered as soon as practicable to: The resident, legal representative, and designated representative. For residents who receive home and community-based waiver services, the resident's case manager, and the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the contract termination process. No further information was provided. 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 record review, the licensee failed to allow the return of one of one resident (R1) after they were sent to the emergency room, although the licensee had not issued a notice of termination of services or housing. Hospital records indicated the licensee would not accept R1 back after being medically cleared to return. The licensee failed to offer any	01070		

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01070	Continued From page 11 option for R1 to return as a housing-only resident with the necessary services provided by another agency. The resident had to stay in the hospital despite being medically cleared for discharge while he waited for other placement. 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). R1's diagnoses included early onset Alzheimer's dementia without behavioral disturbance, bilateral hearing loss, and depression. R1 admitted to the facility on October 10, 2023, and discharged on November 3, 2023. R1's service plan dated October 10, 2023, indicated the resident received assistance with dressing, grooming, bathing, escorts, medication administration, and behavior management. R1's most recent assessment dated November 1, 2023, indicated the resident "had potential for agitation and combativeness as should always have at least two person assist." At least two staff were required due to "safety concerns." R1's progress notes contained the following entries: -November 3, 2023, clinical nurse supervisor (CNS)-C informed the resident's wife about the resident's behaviors the prior night which included "assaulting staff, pulled fire alarm, and assaulted RN writer while trying to pass medications this	01070		

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01070	Continued From page 12 AM...[licensed assisted living director (LALD)-B] was notified of resident behaviors this AM. She then notified this writer that resident needs to be sent to the ER ASAP given the dangerous behaviors." The resident's wife brought the resident to the emergency room for further evaluation. -November 4, 2023, chief executive officer (CEO)-A wrote that LALD-B spoke with the hospital and was informed that "resident will not be returning to us, [R1's wife] decided. Will follow up with [R1's wife] for confirmation." -November 6, 2023, CNS-C documented the resident's wife was at the facility moving the resident's belongings out. Documentation indicated R1's wife asked "if the 30 day notice was from Friday, 11/3 as was told "she cannot bring resident back unless she would stay with resident. Advise writer cannot confirm this and would need to reach out to [CEO-A] or [LALD-B] regarding the billing." Hospital records indicated the resident admitted on November 3, 2023, and had been a resident at "senior class care but had behavioral issues there. Was recently discharged from [acute care medical facility] to senior class care and within 48 hours he was brought back to the nursing home because of behavioral issues. While in the hospital he has not had behavioral problems..." The resident spent three days in the hospital waiting for alternative placement. Hospital records contained a progress note dated November 3, 2023, at 11:02 a.m., which indicated, "Spoke with [clinical nurse supervisor (CNS)-C] at Senior Class Care and she stated they will be sending this patient in and they will not be taking him back as their director told them he was too much for them there and that there	01070		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26533	A. BUILDING: _____ B. WING _____	C 04/10/2024

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01070	Continued From page 13 (sic) too many vulnerable residents that live there. She was assured that we would assess the patient and see what we could do to help, but you can't call stating that you wouldn't be taking the patient back again...She became angry with this writer and said the ED (emergency department) is an example of insanity and that we are just trying to avoid doing our job and hung up on this writer." Hospital social services documented they received a call back from CNS-C at 2:04 p.m., "asking for an update on the referral...she then advised us to tell the patient's wife to take the patient out of this ED and take him to the ED at [another hospital] so the patient would have priority for the bed [at the other hospital]. She was asked to repeat what she just said to make sure I heard it correctly. She repeated to advise the patient's wife to take the patient from this ED and take him to [another hospital] so he would be in their ED and have priority for the bed in [another city] She was told that we would not be telling the wife to take the patient out of this ED to be brought to [other city] hospital. [CNS-C] then stated she would call the patient's wife herself to give her that information. A progress note entered at 2:10 p.m., indicated R1's wife "came out of the patient's room about 2:10 p.m. with her cell phone on speaker phone. She identified she was speaking with [CNS-C] at Senior Class Care. [R1's wife] stood at the nurses desk in the ED so we would hear the conversation. [R1's wife] was told to take the patient to the [other city] hospital to their ED so he would have priority for the bed at [other city] [R1's wife] said back to [CNS-C] several times that she would not be taking the patient out of this ED and bringing him to the [other city] hospital. [CNS-C] tried to explain that the patient needs this and she didn't want them to lose the bed there. [R1's wife] ended the conversation that she would not take him out of	01070		

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01070	Continued From page 14 the ED as there was no guarantee what would happen then." After R1's wife ended the call with CNS-C, she expressed concern about bringing the resident back to the facility and how they might treat him if he returned. Hospital records indicated another discharge planner received an email "from the director at Senior Class Care stating the patient could return there but [R1's wife] would have to stay there with the patient until something else is figured out." On April 11, 2024, at 11:50 a.m., LALD-B stated she was on vacation when R1 was sent to the hospital and the situation was handled by CNS-C and the way it was handled was not consistent with how they normally work with the local hospital. LALD-B stated CNS-C had told her she never told the resident they couldn't return to the facility but she was aware CNS-C had been rude to hospital staff. LALD-B stated the resident should have had the right to return. LALD-B stated shortly after this incident occurred, CNS-C was let go from her position due to her inability to take direction. "We thought hiring a nurse practitioner [as the CNS] would be a great thing and it was just not." On April 11, 2024, at 1:30 p.m., R1's wife stated she was under the impression the facility couldn't care for the resident and they were giving her notice to move out. R1's wife stated she told CNS-C "I'm under the understanding you're giving me notice [to move out]" but CNS-C would not confirm or deny she was being asked to move out. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	01070		

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01070	Continued From page 15 days.	01070		