STATE LICENSING COMPLIANCE REPORT

Report #: HL279684626C

Date Concluded: February 15, 2023

Name, Address, and County of Facility Investigated:
Legacy Care Home
14814 Crown Drive
Minnetonka, MN 55345
Hennepin County

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

Evaluator's Name: Michele R. Larson
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
	27968	A. BUILDING: _____ B. WING _____	C 02/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY CARE HOME	14814 CROWN DRIVE MINNETONKA, MN 55345

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0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL279684626C On February 15, 2023, 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 six residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for #HL279684626C tag identification 1040, 1070.	0 000	Assisted Living Provider 144G. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3	

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01040	Continued From page 1	01040		
01040 SS=D	144G.52 Subd. 7 Notice of contract termination required (a) A facility terminating a contract must issue a written notice of termination according to this section. The facility must also send a copy of the termination notice to the Office of Ombudsman for Long-Term Care and, for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, to the resident's case manager, as soon as practicable after providing notice to the resident. A facility may terminate an assisted living contract only as permitted under subdivisions 3, 4, and 5. (b) A facility terminating a contract under subdivision 3 or 4 must provide a written termination notice at least 30 days before the effective date of the termination to the resident, legal representative, and designated representative. (c) A facility terminating a contract under subdivision 5 must provide a written termination notice at least 15 days before the effective date of the termination to the resident, legal representative, and designated representative. (d) If a resident moves out of a facility or cancels services received from the facility, nothing in this section prohibits a facility from enforcing against the resident any notice periods with which the resident must comply under the assisted living contract. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written 15 day termination notice for R1's expedited termination nor provide notice to the Office of Ombudsman for Long Term Care (OOLTC).	01040		

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01040	Continued From page 2 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). Findings Include: R1's medical record was reviewed. R1 admitted to the facility on August 18, 2022, and discharged September 6, 2022. R1's diagnoses included morbid obesity and borderline personality disorder. R1's service plan dated August 18, 2022, indicated R1 required assistance with daily hygiene, twice daily assistance with dressing, daily medication management, three times per day with meals, toileting every three to four hours, weekly assistance with laundry and bathing, and as needed (PRN) assistance with mental health services. R1's service plan indicated R1 required the assist of one staff person for brief changes while in bed, and an assist of two staff persons with mobility when she used her walker. R1's admission assessment dated August 18, 2022, completed by registered nurse (RN)-B, indicated R1 required partial and assist of two staff members for toileting and bed mobility. A note in R1's assessment dated August 18, 2018, indicated, "Hoyer lift will not lift high enough" to get R1 out of her chair and now R1 is saying she is unable stand. R1 stood and walked with her walker to get into her chair with minimal assistance.	01040		

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01040	Continued From page 3 R1's progress note dated August 18, 2022, (time unknown), indicated R1 barely fit through the facility front door due to R1's wheelchair and arms touched the sides of the doorway. RN-B indicated the facility did not make modifications prior to R1's arrival due to the hospital and case manager wanted R1, "discharged ASAP." R1 was able to walk with minimal assistance using her her walker to sit in her recliner. A noted by RN-B dated August 18, 2022, indicated emergency medical services (EMS) was called. R1 was transported to a hospital due to facility's Hoyer lift did not raise R1 high enough to clear the recliner where R1 sat. R1 spent 12 days in the hospital before she was allowed to return to the facility. R1's progress note dated August 30, 2022, written by RN-B, indicated R1 returned to the facility at 3:30 p.m. R1 was able to stand and use her walker to get into her bed. RN-B wrote, "R1 appears to be at baseline." R1 indicated she was able to assist staff with her cares. R1's service delivery record dated September 1-4, 2023, indicated unlicensed personnel documented the following for R1's brief changes and personal cares: 9/1/22: (time unknown): unlicensed personnel (ULP)-C-"no concerns." ULP-D-"no concerns." ULP-E-"no concerns." ULP-F-"no concerns." ULP-G-"no concerns." 9/2/22: (time unknown): ULP-C-"no concerns." ULP-D-"no concerns." ULP-E-"no concerns." ULP-F-"no concerns." ULP-G-"no concerns." ULP-H-"no concerns." 9/3/22: (No services documented)	01040		

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01040	Continued From page 4 9/4/22: ULP-D-"no concerns." ULP-E-"it's been hard for her to stand. Feel weak all day. She has an appt. next Thursday." ULP-C-"no concerns." ULP-G-"when changing R1 I would only use while sleep." ULP-H-"had x-ray taken today. Seems to be healing pretty well. Still in pain." R1's service delivery record lacked documentation R1 refused to assist with her cares. R1's two progress notes dated September 2, 2022, indicated R1 told her fiancée the facility did not provide her meals. RN-B indicated R1 ate four to six large meals per day. RN-B discussed R1's food situation with R1's fiancée. RN-B wrote, "R1 is upset and says she hates this writer." R1 refused to assist with her cares after RN-B spoke to R1's fiancée. 911 was called to assist in turning R1 after staff were unable to turn her. EMS arrived but refused to take R1 to the hospital. RN-B contacted R1's case manager indicating R1 needed to move to a facility that "could handle a four to seven person assist and her behaviors." R1's progress note dated September 6, 2022, indicated EMS transported R1 to the hospital after staff were unable to turn and change her. RN-B indicated a hospital social worker called RN-B after R1's arrival at the hospital. RN-B indicated R1's fiancée was told the facility was unable to allow R1 to return due to R1's significant change-in-condition, requiring a four to seven person assist. R1's record lacked a written 15-day notice of expedited termination of R1's contract and services. R1's record lacked documentation a copy of a	01040		

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01040	Continued From page 5 termination notice was sent to the Office of Ombudsman for Long-Term Care (OOLTC). R1's discharge summary dated September 6, 2022, indicated R1 was discharged due to change-in-condition, indicating "2 assist changed to 4 to 7 person assist. Not safe environment." R1's discharge summary indicated R1 was stable at the time of her discharge. R1's medications would be held for 30 days, then destroyed on October 7, 2022, unless R1 planned to pick up. On February 23, 2023, at 12:16 p.m., RN-B confirmed she did not provide OOLTC a written notice of R1's expedited termination of contract. The licensee policy titled Emergency Relocation, updated August 1, 2021, indicated a written notice of an emergency relocation would be delivered as soon as practicable to the OOLTC if the resident was relocated and did not return to the facility within four days. The licensee policy for Resident Termination Notice, included a template with the required content to issue a termination notice, include check boxes for type of notice: 30-day notice for nonpayment, 30-day notice for violation of the contract and 15-day expediated notice. TIME PERIOD TO CORRECT: Seven (7) days.	01040		
01070 SS=G	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.	01070		

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01070	Continued From page 6 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee did not allow the return of one former resident (R1) with record reviewed. The licensee failed to provide notice of an expedited termination to R1. The licensee sent R1 to the hospital for extensive assistance with cares and refused to allow her to return. 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). Findings Include: R1's medical record was reviewed. R1 admitted to the facility on August 18, 2022, and discharged September 6, 2022. R1's diagnoses included morbid obesity and borderline personality disorder. R1's service plan dated August 18, 2022, indicated R1 required assistance with daily hygiene, twice daily assistance with dressing, daily medication management, three times per day with meals, toileting every three to four hours, weekly assistance with laundry and bathing, and as needed (PRN) assistance with mental health services. R1's service plan indicated R1 required the assist of one staff person for brief changes while in bed, and an assist of two staff persons with mobility when she used her walker.	01070		

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01070	Continued From page 7 R1's admission assessment dated August 18, 2022, completed by registered nurse (RN)-B, indicated R1 required partial and assist of two staff members for toileting and bed mobility. A note in R1's assessment dated August 18, 2018, indicated, "Hoyer lift will not lift high enough" to get R1 out of her chair and now R1 is saying she is unable stand. R1 stood and walked with her walker to get into her chair with minimal assistance. R1's progress note dated August 18, 2022, (time unknown), indicated R1 barely fit through the facility front door due to R1's wheelchair and arms touched the sides of the doorway. RN-B indicated the facility did not make modifications prior to R1's arrival due to the hospital and case manager wanted R1, "discharged ASAP." R1 was able to walk with minimal assistance using her her walker to sit in her recliner. A noted by RN-B dated August 18, 2022, indicated emergency medical services (EMS) was called. R1 was transported to a hospital due to facility's Hoyer lift did not raise R1 high enough to clear the recliner where R1 sat. R1 spent 12 days in the hospital before she was allowed to return to the facility. R1's progress note dated August 30, 2022, written by RN-B, indicated R1 returned to the facility at 3:30 p.m. R1 was able to stand and use her walker to get into her bed. RN-B wrote, "R1 appears to be at baseline." R1 indicated she was able to assist staff with her cares. R1's service delivery record dated September 1-4, 2023, indicated unlicensed personnel documented the following for R1's brief changes	01070		

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01070	Continued From page 8 and personal cares: 9/1/22: (time unknown): unlicensed personnel (ULP)-C-"no concerns." ULP-D-"no concerns." ULP-E-"no concerns." ULP-F-"no concerns." ULP-G-"no concerns." 9/2/22: (time unknown): ULP-C-"no concerns." ULP-D-"no concerns." ULP-E-"no concerns." ULP-F-"no concerns." ULP-G-"no concerns." ULP-H-"no concerns." 9/3/22: (No services documented) 9/4/22: ULP-D-"no concerns." ULP-E-"it's been hard for her to stand. Feel weak all day. She has an appt. next Thursday." ULP-C-"no concerns." ULP-G-"when changing R1 I would only use while sleep." ULP-H-"had x-ray taken today. Seems to be healing pretty well. Still in pain." R1's service delivery record lacked documentation R1 refused to assist with her cares. R1's two progress notes dated September 2, 2022, indicated R1 told her fiancée the facility did not provide her meals. RN-B indicated R1 ate four to six large meals per day. RN-B discussed R1's food situation with R1's fiancée. RN-B wrote, "R1 is upset and says she hates this writer." R1 refused to assist with her cares after RN-B spoke to R1's fiancée. 911 was called to assist in turning R1 after staff were unable to turn her. EMS arrived but refused to take R1 to the hospital. RN-B contacted R1's case manager indicating R1 needed to move to a facility that "could handle a four to seven person assist and her behaviors." R1's progress note dated September 6, 2022, indicated EMS transported R1 to the hospital after staff were unable to turn and change her. RN-B indicated a hospital social worker called	01070		

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01070	Continued From page 9 RN-B after R1's arrival at the hospital. RN-B indicated R1's fiancée was told the facility was unable to allow R1 to return due to R1's significant change-in-condition, requiring a four to seven person assist. R1's record lacked a written 15-day notice of expedited termination of R1's contract and services. R1's record lacked documentation a copy of a termination notice was sent to the Office of Ombudsman for Long-Term Care (OOLTC). R1's discharge summary dated September 6, 2022, indicated R1 was discharged due to change-in-condition, indicating "2 assist changed to 4 to 7 person assist. Not safe environment." R1's discharge summary indicated R1 was stable at the time of her discharge. R1's medications would be held for 30 days, then destroyed on October 7, 2022, unless R1 planned to pick up. An email dated February 15, 2023, at 3:21 p.m., indicated RN-B told R1's case manager R1 could return if she was at her admission baseline assessment. The email indicated RN-B had several discussions with R1 about R1's unwillingness to assist with cares, indicating it would not work if it continued. RN-B indicated R1 agreed to be transported to the hospital and not return due to her care level and needs. On February 15, 2023, at 10:18 a.m., social worker (SW)-A stated R1 spent two months in the hospital's emergency center after R1's eviction from the facility. SW-A stated the hospital had past issues with the facility. SW-A stated on December 7, 2022, R1 was discharged to another facility.	01070		

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01070	Continued From page 10 On February 23, 2023, at 12:16 p.m., RN-B stated she "technically" did not discharge R1, stating, " I always said R1 could return here if she was at her baseline at the time I initially assessed her." A report dated September 14, 2022, indicated the licensee's requirement for R1 to return to the facility was R1 would be an assist of two staff persons and would cooperate with her cares. The report indicated R1 agreed she only required assistance from two staff persons and would help staff with her cares. SW-A contacted owner (OW)-I to inform him of the agreement but, OW-I refused to allow R1 to return and would not discuss R1's eviction. SW-A informed OW-I hospitals did not admit people for placement, but OW-I continued to refuse to allow R1 to return. SW-A wrote, "R1 did want to return "home" and is still cooperating here." TIME PERIOD OF CORRECTION: Seven (7) Days	01070		