STATE LICENSING COMPLIANCE REPORT

Report #: HL305464256C **Date Concluded:** June 15, 2024

Name, Address, and County of Facility Investigated:
Elk Ridge Assisted Living
821 7th Avenue SW
Perham, MN 56573
Otter Tail County

Facility Type: Assisted Living Facility (ALF) **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
	30546	A. BUILDING: _____ B. WING _____	C 06/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELK RIDGE ASSISTED LIVING SC	821 7TH AVENUE SW PERHAM, MN 56573

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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: #HL305464256C On June 5, 2024, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction order is issued. At the time of the complaint investigation, there were four (4) residents receiving services under the provider's Assisted Living license. The following correction orders are issued. The following immediate correction order is issued for #HL305464256C, tag identification 1290. The immediacy was removed as of June 14, 2024; however, noncompliance remained at a lowered scope and severity. The following correction orders are issued for #HL305464256C, tag identification 0250, 2340.	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 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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0 250	Continued From page 1	0 250		
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 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;	0 250		

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0 250	Continued From page 2 (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 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 June 5, 2024, at 1:45 p.m., the investigator called owner (O)-A to initiate a complaint	0 250		

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0 250	Continued From page 3 investigation and left a voicemail requesting a call back. On June 5, 2024, at 1:54 p.m., the investigator emailed O-A requesting a call back. O-A called back on June 6, 2024, at 8:20 a.m. On June 10, 2024, at 11:11 a.m., the investigator emailed O-A a list of employee background studies to be sent for review. A deadline of June 10, 2024, at 4:00 p.m. was given. No information was received by the deadline. On June 11, 2024, at 6:58 a.m., the investigator emailed O-A to advise no response had been received and the information needed to be submitted by June 11, 2024, at noon. The email indicated failure to provide the requested information would result in a correction order related to failing to fully cooperate with an investigation. On June 11, 2024, at 11:15 a.m., the investigator called O-A. O-A confirmed he had received the emails requesting information but he wasn't able to locate anything and he would have to drive two hours to the facility to check the employee files. On June 11, 2024, at 12:52 p.m., O-A confirmed he was not able to locate the requested background study clearance letters. On June 12, 2024, at 2:20 p.m., an immediate order was emailed to O-A. The email indicated O-A was to reply all to the email to acknowledge receipt of the immediate order and to communicate about the status of your immediate plan of correction regarding the immediate correction order. O-A did not reply to the email or provide a plan of correction.	0 250		

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0 250	Continued From page 4 On June 13, 2024, at 6:23 a.m., the investigator emailed O-A to confirm he had received the immediate order email and requested additional information related to three residents. The email indicated failure to provide the requested information would result in a correction order related to failing to fully cooperate with an investigation. The investigator also requested records for three residents to include a face sheet, assisted living agreement, signed service plan, progress notes for January 1st through June 13th, two most recent assessments, and six months of billing statements. A deadline of June 13, 2024, at 4:00 p.m. was given. O-A did not respond to the request or provide any information. On June 13, 2024, at 2:12 p.m., the investigator emailed licensed assisted living director/clinical nurse supervisor (LALD/CNS)-B to see if O-A had shared the immediate order with her and if a plan of correction had been created. LALD/CNS-B replied at 2:54 p.m. and wrote, "No, he did not." LALD/CNS-B stated she had a group text message with O-A and the other facility nurse but O-A had not replied to any messages. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter	01290		

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01290	Continued From page 5 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study was submitted and received in affiliation with the assisted living license for four of four employees unlicensed personnel (ULP)-D, ULP-E, ULP-F, and maintenance assistant (M)-G). This resulted in an immediate correction order issued on June 11, 2024. The immediacy was removed as of June 14, 2024; however, noncompliance remained at a lowered scope and severity. 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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The finding include: On June 11, 2024, at 11:50 a.m., the investigator compared the facility's employee list to the licensee's Minnesota Department of Human	01290		

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01290	Continued From page 6 Services (DHS) NETStudy 2.0 roster and identified four employees who were not on the roster for health facility identification numbers (HFID) 27188, 30546, or 31250. ULP-D ULP-D was hired on May 28, 2024, and provided direct care and services to residents. ULP-D's record lacked evidence of a completed BGS. A search of the employee on the NETStudy 2.0 website on June 11, 2024, did not return any matches for the employee which would indicate a background study was completed or submitted. A background study was initiated on May 23, 2024, but closed on June 5, 2024, due to a consent disclosure not being completed. ULP-E ULP-E was hired on October 2, 2023, and provided direct care and services to residents. ULP-E's record lacked evidence of a completed BGS. A search of the employee on the NETStudy 2.0 website on June 11, 2024, did not return any matches for the employee which would indicate a background study was completed or submitted. ULP-F ULP-F was hired on March 16, 2024, and provided direct care and services to residents. ULP-F's record lacked evidence of a completed BGS. A search of the employee on the NETStudy 2.0	01290		

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website on June 11, 2024, did not return any matches for the employee which would indicate a background study was completed or submitted.

M-G
M-G was hired on September 1, 2022, and assisted with maintenance related jobs and lawn care.

M-G's record contained a background study clearance notice dated August 17, 2021.

M-G was not currently on the NETStudy 2.0 website roster page for any of the health facility IDs associated with the licensee. A search of the employee indicated he had previously completed a background study but it was a COVID-19 Study and expired on December 31, 2022.

On June 11, 2024, the Minnesota Department of Human Services website indicated as of July 20, 2023, emergency studies completed during the COVID-19 pandemic were no longer valid. If an individual who was still affiliated had not had a new fingerprint-based background study submitted since their emergency study expired, then the entity is not compliant with state and federal background study requirements. A new fingerprint-based study must be submitted immediately in NETStudy 2.0 for individuals who do not have one.

On June 11, 2024, at 1:05 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-B stated only owner (O)-A had access to submit and complete background studies. LALD/CNS-B stated their process for onboarding new employees would be O-A submitted all of the information and he would send her or the other registered nurse a text

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01290	Continued From page 8 message which indicated the employee was good to go and ok to start working. LALD/CNS-B confirmed all four employees were current employees who would have contact with residents and did not have one on one supervision. On June 11, 2024, at 2:20 p.m., O-A stated he had submitted background studies but did not have access to view the facility's roster. O-A stated he thought background studies had been completed but did not have any documentation to show they had been submitted. A review of NETStudy 2.0 website on June 11, 2024, indicated the licensee's previous owner was the sensitive information person (SIP) and O-A was only listed as an authorized agent. A policy on background studies was requested, but not provided. No further information provided. TIME PERIOD FOR CORRECTION: Immediate	01290		
02340 SS=E	144G.91 Subd. 6 Participation in care and service planning Residents have the right to actively participate in the planning, modification, and evaluation of their care and services. This right includes: (1) the opportunity to discuss care, services, treatment, and alternatives with the appropriate caregivers; (2) the right to include the resident's legal and designated representatives and persons of the resident's choosing; and (3) the right to be told in advance of, and take an	02340		

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active part in decisions regarding, any recommended changes in the service plan.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to allow the resident to actively participate in the planning, modification, and evaluation of their care and denied the resident the right to be told in advance of, and take part in, decisions regarding recommended changes for two of two residents (R1, R2) when the licensee failed to provide billing statements or information about the resident's charges.

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:

On June 6, 2024, at 8320 a.m., owner (O)-A confirmed he was responsible for billing and created the statements each month to initiate the withdrawal of funds from the resident's authorized bank account.

R1
R1's diagnoses included severe neurocognitive disorder with paranoia and behavioral complications and Alzheimer's disease.

R1's service plan dated September 12, 2023, indicated the resident received assistance with

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dressing, grooming, bathing, wound care, and medication administration. The estimated monthly total for the cost of the services was listed as $0.00.

R1 admitted to the facility on September 12, 2023.

R1's Assisted Living Contract dated September 12, 2023, indicated on page 6 Fees for Services will be applied and made known to the resident and/or family. Page 7 indicated "The facility will provide you with a monthly bill showing charges for the Monthly Base Fee and the fees for any additional services provided to you."

R1's bank statements indicated the licensee withdrew the following amounts from the resident's bank account:
-March 1, 2024, Elkridge ACH withdrew $6,600
-February 2, 2024, Elkridge ACH withdrew $6,600
-January 3, 2024, Elkridge ACH withdrew $13,200
-December 1, 2023, Elkridge ACH withdrew $13,200

The bank statement indicated a $6,600 check was cashed by the licensee on April 2, 2024, and again on May 2, 2024.

Documentation maintained by R1's responsible party indicated she noticed on March 5, 2024, that April rent of $6,600 was withdrawn on March 1, 2024, and she emailed the licensed assisted living director/clinical nurse supervisor (LALD/CNS)-B that she had discussed she would be mailing checks going forward. The documentation indicated the responsible party spoke with LALD/CNS-B on March 8, 2024, to voice concerns about the amounts being withdrawn for rent. The documentation indicated

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the responsible party spoke with the former owner of the facility on March 11, 2024, after the former owner called about monthly withdrawals and stated that no more withdrawals would be made from the account. The note indicated the former owner told her checks must be received by the fifth of the month to avoid any fees.

On June 13, 2024, the investigator requested owner (O)-A email documentation related to R1 to include a face sheet, assisted living agreement, signed service plan, progress notes for January 1st through June 13th, two most recent assessments, and six months of billing statements. O-A did not respond to the request or provide any information.

On June 13, 2024, the investigator requested licensed assisted living director/clinical nurse supervisor (LALD/CNS)-B email documentation related to R1 to include a face sheet, assisted living agreement, signed service plan, progress notes for January 1st through June 13th, two most recent assessments, and six months of billing statements. LALD/CNS-B emailed records including a service plan, contract, assessments, and progress notes but stated she was not able to locate billing statements and did not have access to statements as they were handled exclusively by O-A. LALD/CNS-B stated if documents like the agreement or service plan were not scanned into the computer, she wouldn't be able to access them.

On June 14, 2024, R1's responsible party stated she had some concerns with the billing practices of the facility since the time R1 moved into the facility. O-A stated the facility did not bill her at all for November services but double billed her in December, which she thought was odd that a

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business would forget to bill for a month. The responsible party stated they paid via automatic withdrawals from a checking account and it totaled $6,600 a month. The responsible party stated she was billed twice, a total of $13,200, in January and February and after that she revoked the facility's ability to take automatic payments from the bank account and told O-A she would only pay by check. The responsible party stated she never received any billing statements and "that would have made sense, then we would have caught they missed November. We never knew what was going on, the communication wasn't so good." The responsible party stated she didn't realize they were supposed to be receiving monthly statements. The responsible party stated when R1 began to decline and enter end of life, she sent the monthly check but wrote on the check to not cash it until June 1st in case the resident passed away prior to then. The responsible party stated the resident died and she tried to reach out to O-A and LALD/CNS-B was able to get ahold of him and he had said he could destroy the check since it was still in his wallet. "I thought that was a weird thing to say that it was in his wallet."

R2
R2's diagnoses included Alzheimer's disease and depression.

R2 admitted to the facility on March 15, 2023.

R2's record lacked a signed service plan.

R2's record lacked a signed assisted living contract.

On June 14, 2024 R2's responsible party stated she had never received any billing statements

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30546	A. BUILDING: _____ B. WING _____	C 06/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELK RIDGE ASSISTED LIVING SC	821 7TH AVENUE SW PERHAM, MN 56573

(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
02340	Continued From page 13 from the facility and if she ever had questions on billing, she was never able to speak with O-A directly and communication went through LALD/CNS-B. R2's responsible party stated they had started to pay a different amount due to the resident possibly receiving county assistance and when that wasn't approved, they had to pay back the balance due and even then, she couldn't communicate directly with O-A and was never sent a formal payment plan or any kind of agreement, which she would have expected from a business. On June 13, 2024, the investigator requested O-A email documentation related to R2 to include a face sheet, assisted living agreement, signed service plan, progress notes for January 1st through June 13th, two most recent assessments, and six months of billing statements. O-A did not respond to the request or provide any information. On June 13, 2024, the investigator requested LALD/CNS-B email documentation related to R2 to include a face sheet, assisted living agreement, signed service plan, progress notes for January 1st through June 13th, two most recent assessments, and six months of billing statements. LALD/CNS-B emailed an April 2024 billing statement which showed $1,135 was due for rent. The billing statement indicated it was sent to the resident, not her responsible party. LALD/CNS-B stated she was not able to locate any other documentation or billing statements and did not have access to statements as they were handled exclusively by O-A. LALD/CNS-B provided progress notes and two assessments but was not able to locate any other documentation.	02340		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02340	Continued From page 14 The Minnesota Assisted Living Resident Bill of Rights dated November 8, 2022, indicated residents have the right to actively participate in the planning, modification, and evaluation of their care and services. This right includes the opportunity to discuss care, services, treatment and alternatives with the appropriate caregivers in advance of changes. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02340		