STATE LICENSING COMPLIANCE REPORT

Report #: HL306155921C **Date Concluded: March 10, 2023**

Name, Address, and County of Facility Investigated:
Reflections
300 2nd Street SW
Austin, MN 55912
Mower 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
	30615	A. BUILDING: _____ B. WING _____	C 03/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REFLECTIONS	300 2ND STREET SW AUSTIN, MN 55912

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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: #HL306155921C On March 6, 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 no residents receiving services under the provider's Assisted Living license. The following correction order is issued/orders are issued for #HL306155921C, tag identification 0110, 1240, 1260.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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.	
0 110 SS=C	144G.10 Subdivision 1a Assisted living director license required Each assisted living facility must employ an	0 110		

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0 110	Continued From page 1 assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports.? This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensed assisted living director (LALD) was listed as the Director of Record for the licensee. This had the potential to affect all the licensee's residents, staff, and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), 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 findings include: During the entrance conference on March 6, at 11:00 a.m., licensed assisted living director (LALD)-A confirmed she served as the LALD for the facility. LALD-A stated she also oversaw additional facility locations owned by the licensee, however those were not licensed as assisted living facilities. The LALD confirmed this facility closed and ended operations on November 14, 2022. On March 6, 2023, the investigator reviewed the Board of Executives for Long-Term Services and Support (BELTSS) website with LALD-A. The BELTSS website indicated LALD-A had her assisted living director license effective June 24, 2021 through October 31, 2023. The website did	0 110		

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0 110	Continued From page 2 not identify LALD-A as the Director of Record for the licensee, this section was left blank. LALD-A stated she was not sure why the website did not reflect her history of working as the LALD at the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
01240 SS=F	144G.57 Subd. 3 Commissioner's approval required prior to imp (a) The plan shall be subject to the commissioner's approval and subdivision 6. The facility shall take no action to close the residence prior to the commissioner's approval of the plan. The commissioner shall approve or otherwise respond to the plan as soon as practicable. (b) The commissioner may require the facility to work with a transitional team comprised of department staff, staff of the Office of Ombudsman for Long-Term Care, the Office of Ombudsman for Mental Health and Developmental Disabilities, and other professionals the commissioner deems necessary to assist in the proper relocation of residents. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee closed the assisted living facility prior to the Minnesota Department of Health's (MDH's) approval of the licensee's closure plan. The licensee executed a relocation plan for all four residents, including transferring the residents to a new location, prior to notifying MDH.	01240		

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01240	Continued From page 3 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 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: The Minnesota Department of Health received a closure form from the licensee at 2:31 p.m. on October 31, 2022. The closure form indicated the proposed effective date of closure was November 30, 2022. On November 1, 2022, correspondence from MDH was sent to the licensee indicating the closure form was not complete and the required Closure Plan was not included and it needed to be sent ASAP. The correspondence indicated the licensee was not allowed to take any action to close the residence until the commissioner's approval of the plan; including not notifying residents of the proposed closure or take any action to carry out the closure until the plan was approved. MDH records indicate on November 2, 2022, site manager (SM)-B spoke with a consumer advocate and mentioned they had already told the residents and guardians that they would close by the end of November but would "have to check with [LALD-A] to determine if a closure plan had been submitted to all required agencies." MDH records indicated that on November 8, 2022, SM-B sent an email which stated "Due to	01240		

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01240	Continued From page 4 us being a small town and only having four residents, word got out about our planned closure. Each of our residents have found new facilities that they are choosing to move to. Our last resident will be moving on November 14, 2022. We will at this time have no residents to serve. We would like to proceed with closure as soon as possible." MDH records indicated on November 21, 2022, SM-B sent an email informing the state "...We no longer have residents in our AL [assisted living] as of 11/14/22, and are wondering what else needs to be done for the licenses (sic) to be closed?" On March 6, 2023, at 11:00 a.m., licensed assisted living director (LALD)-A stated she had sent in a closure form on September 22, 2022, and later realized that form only went to the Ombudsman office and not the appropriate office with the Minnesota Department of Health. LALD-A stated the facility was getting calls from nursing homes and others in the community about their closure and word had been "traveling very fast." LALD-A stated she was not entirely sure how word got out to the community that their building was closing and due to that they ended up closing sooner than anticipated. LALD-A stated they only had four residents in the facility and the location was not sustainable due to overall staffing and the inability to find a nurse. On March 6, 2023, at 11:50 a.m., county case manager (CM)-D stated she followed a resident who resided at the facility, R1. CM-D stated she was not formally notified of the facility's plan to close and only heard about it through a coworker. CM-D stated she was concerned because R1 had moved to the facility only a few months prior after	01240		

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01240	Continued From page 5 the previous facility he was residing at closed. CM-D stated she was worried about the disruption this would cause for R1 and didn't know if they'd have enough time to find housing and that they might need to change his waiver status to find a new place to live. CM-D stated she asked the facility about their closure and was told they were going to close but had not told their staff yet as they didn't want to lose any employees. On March 6, 2023, at 12:05 p.m., R1's guardian, G-C, stated he didn't get notified of the closure and that "everything happened really fast." G-C stated it was a scramble to get it done quickly and the local human services department helped with the relocation. G-C stated, "Everything happened fast, I was amazed at what a short term thing it was, when they announced the closing it was over and done with in short order, we were just gone. I didn't get any information." G-C stated R1 did not like being uprooted and had already moved once this year when his previous facility closed. On March 6, 2023, at 12:20 p.m., SM-B stated they had missed sending a part of paperwork to MDH and the initial notice only went to the ombudsman. SM-B stated shortly after that notice was sent, she began reaching out to other local providers to see what they had for openings and stated, "I think with me reaching out and asking questions put us on the radar and suddenly I'm getting "are you guys closing?" questions." SM-B stated since some places had openings and they were places two of the residents wanted to go, she reached out to their guardians since she wanted to get the openings while they still had them. SM-B stated everything had happened really fast and "when people got wind of it, I'm not	01240		

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01240	Continued From page 6 going to lie to them about it and I wanted them to have that option. I feel like it worked out really well." SM-B confirmed R1 was hesitant to move and had "major anxiety" but once he got settled in his new facility, he fit in well and was really happy. On March 6, 2023, at 12:45 p.m., R1 stated he had been anxious to move but was really happy at his new facility and liked living there. R1 did not recall many details from the closure process or what notice he had received. Review of MDH documentation on March 6, 2023, indicated that MDH had not approved the licensee's closure plan at any time. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days	01240		
01260 SS=F	144G.57 Subd. 5 Notice to residents After the commissioner has approved the relocation plan and at least 60 calendar days before closing, except as provided under subdivision 6, the facility must notify residents, designated representatives, and legal representatives of the closure, the proposed date of closure, the contact information of the Ombudsman for Long-Term Care and the Ombudsman for Mental Health and Developmental Disabilities, and that the facility will follow the termination planning requirements under section 144G.55, and final accounting and return requirements under section 144G.42, subdivision 5. For residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the facility	01260		

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01260	Continued From page 7 must also provide this information to the resident's case manager. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to provide residents, the ombudsman of long-term care, and a case manager, with a written closure notification at least 60 calendar days before initiating the facility closure. 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 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 the residents). Findings Include: On May 9, 2022, licensed assisted living director (LALD)-A submitted a signed renewal application to the Minnesota Department of Health on behalf of the licensee acknowledging the licensee reviewed and understood Minnesota Statutes, Rules, and requirements related to assisted living licensure. On August 1, 2022, the licensee was issued an Assisted Living Facility license effective through June 30, 2023. The Minnesota Department of Health received a closure form from the licensee at 2:31 p.m. on October 31, 2022. The closure form indicated the proposed effective date of closure was November 30, 2022.	01260		

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01260	Continued From page 8 On November 1, 2022, correspondence from MDH was sent to the licensee indicating the closure form was not complete, the required Closure Plan was not included, and it needed to be sent ASAP. The correspondence indicated the licensee was not allowed to take any action to close the residence until the commissioner's approval of the plan; including not notifying residents of the proposed closure or take any action to carry out the closure until the plan was approved. MDH records indicate on November 2, 2022, site manager (SM)-B spoke with a consumer advocate and mentioned they had already told the residents and guardians that they would close by the end of November but would "have to check with [LALD-A] to determine if a closure plan had been submitted to all required agencies." MDH records indicated on November 8, 2022, SM-B sent an email which included "Due to us being a small town and only having four residents, word got out about our planned closure. Each of our residents have found new facilities that they are choosing to move to. Our last resident will be moving on November 14, 2022. We will at this time have no residents to serve. We would like to proceed with closure as soon as possible." MDH records indicated on November 21, 2022, SM-B sent an email informing the state "...We no longer have residents in our AL [assisted living] as of 11/14/22, and are wondering what else needs to be done for the licenses (sic) to be closed?" On March 6, 2023, at 11:50 a.m., county case manager (CM)-D stated she followed a resident	01260		

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01260	Continued From page 9 who resided at the facility, R1. CM-D stated she was not formally notified of the facility's plan to close and only heard about it through a coworker. CM-D stated she asked the facility about their closure and was told they were going to close but had not told their staff yet as they didn't want to lose any employees. On March 6, 2023, at 12:05 p.m., R1's guardian, G-C, stated he didn't get notified of the closure. G-C stated, "Everything happened fast, I was amazed at what a short term thing it was, when they announced the closing it was over and done with in short order, we were just gone. I didn't get any information." On March 6, 2023, at 12:20 p.m., SM-B stated they had missed sending a part of paperwork to MDH and the initial notice only went to the ombudsman. SM-B stated shortly after that notice was sent, she began reaching out to other local providers to see what they had for openings and stated, "I think with me reaching out and asking questions put us on the radar and suddenly I'm getting "are you guys closing?" questions." SM-B stated everything had happened really fast and "when people got wind of it, I'm not going to lie to them about it and I wanted them to have that option. I feel like it worked out really well." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days	01260		