

STATE LICENSING COMPLIANCE REPORT

Report #: HL328253433C

Date Concluded: May 9, 2023

Name, Address, and County of Facility

Investigated:

A-1 Reliable

5716-42nd Ave N

Robbinsdale, MN 55442-1632

Hennepin County

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

Evaluator's Name: Lori Pokela R.N.

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.

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 32825	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 04/17/2023
NAME OF PROVIDER OR SUPPLIER A-1 RELIABLE HOME CARE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 5716 42ND AVENUE NORTH ROBBINSDALE, MN 55422		
(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 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: *****REVISED***** The previous State Form received May 19, 2023 was revised under tag 1140 and 1260. Specifically the date of June 16, 2023 was revised to reflect the accurate date of June 16, 2022. No other changes were made to this State form. HL328253413C HL328253433C On April 17, 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 with Dementia Care license. The following correction orders are issued for	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	

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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0 000	Continued From page 1 #HL328253413C, #HL328253433C, tag identification: 1140, 1240, and 1260.	0 000	ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
01140 SS=D	144G.55 Subd. 3 Relocation plan required The facility must prepare a relocation plan to prepare for the move to a new safe location or appropriate service provider, as required by this section. This MN Requirement is not met as evidenced by: Based on observation, record review and interview, licensee failed to prepare a relocation plan that included documentation of considerations for the care needs, psychosocial impacts of moving, and accounting of resident's property, prior to initiating the transfer of one of one residents (R1) receiving assisted living services. R1 was transferred to the hospital temporarily while finding a new residence. Due to the resident's diagnoses, this violation had the potential to cause significant decline in the resident's physical and mental health. 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). The findings include: Review of Minnesota Department of Health (MDH) documentation on April 17, 2023, indicated MDH had no record the licensee	01140		

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01140	Continued From page 2 provided notification to MDH the licensee was closing. On May 25, 2022, the licensee's assisted living licensure was approved for renewal per MDH. On April 17, 2023, the MDH investigator arrived at the licensee at approximately 11:22 a.m. and no one answered the licensee's front door. The licensee had no cars or activity, and the facility appeared vacant. A phone call was made to the licensee and the phone number was no longer in service. On April 17, 2023, at approximately 12:13 p.m., the MDH investigator arrived at the licensee's corporate offices. The office door contained a sign that indicated office hours for this date would be from 10:00 a.m. to 5:00 p.m. No one answered the corporate office door. R1: R1's guardian (FM)-C sent an email to the MDH investigator dated April 20th, 2023, at 8:51 a.m. that indicated R1 was admitted to the licensee on December 28, 2020. During an interview on April 20, 2023, at 9:43 a.m., FM-C stated R1's diagnoses included schizoid-affective disorder and bipolar disorder. On April 19, 2023, at 3:16 p.m., FM-C provided a document titled Individual Recovery Plan, dated June 15, 2022, to December 12, 2022, that indicated on June 15, 2022, R1 was continuing to reside at the licensee and that the licensee was purchased by another company that will house R1 in a larger building complex. This same document indicated COVID-19 protocol had made it difficult for R1 to have visitors or go out	01140			

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01140	Continued From page 3 into the community often and that R1 had declined mental health therapy services. An email provided on April 20, 2023, at 12:31 p.m., by R1's case manager, (SW)-A, indicated she was never notified of the licensee closure at any time. An email was provided on April 20, 2023, at 2:36 p.m., by FM-C, indicated FM-C received a letter of closure on June 16, 2022, at 8:53 a.m. from the licensee's operations manager, (ADM)-E. This letter to FM-C indicated R1's case manager, who was no longer employed, was informed of the licensee's closure on May 15, 2022, via a letter of closure. R1's hospital records dated June 17, 2022, at 10:55 a.m., indicated R1 was admitted to the emergency department on July 17, 2022, at 10:55 a.m., due to R1's assisted living licensee closing. During an interview on April 17, 2023, at 3:45 p.m., with the licensed assisted living director/owner, (LALD)-B stated the licensee had closed the facility effective as of May 5, 2022, and all paperwork had been turned in to the state agency for closure. LALD-B also stated in this same interview, that the licensee was in litigation and the licensee's attorney had all documents pertaining to the licensee and advised the licensee not to give the documents to anyone. During an interview on April 17, 2023, at 4:49 p.m., SW-A stated her organization was notified by the county of which the licensee's corporate offices are located, that the licensee was under an investigation and this letter was dated May 13, 2022, and sent to SW-A's department on approximately June 2, 2022. After SW-A was	01140		

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01140	Continued From page 4 notified on June 2, 2022, (SW)-A contacted FM-C, on June 8, 2022. SW-A stated the licensee made unsuccessful attempts to find placement for R1 and R1 was not being taken to scheduled medical appointments. SW-A stated she (SW-A), and FM-C collaborated together to have R1 transported to the hospital on June 16, 2022, temporarily, for evaluation while a new location was found for R1. During an interview on April 18, 2023, at 4:09 p.m. and April 20, 2023, at 9:43 a.m., FM-C stated on June 16, 2022, he received notice from the licensee's county, that the licensee's licensure was going to be suspended. FM-C then stated he called the licensee on June 16, 2022, to inquire about the licensure suspension and was informed by the licensee's staff member that FM-C had approximately one week to find new placement for R1 due to licensee closure. FM-C stated in this same interview, that licensee staff also informed FM-C, that R1's case manager was notified on May 15, 2022, of licensee closure, but also informed FM-C, that the case manager was no longer employed since the case manager received the notification. During an interview on April 20, 2023, at 3:58 p.m., R1's mental health case worker, (SW)-D, stated she was not notified of the facility closing until FM-C informed her after R1 was in the hospital awaiting new placement. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01140		

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01240	Continued From page 5	01240			
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 document review and interview, the licensee failed to provide notice of intent to close the licensee to the commissioner before initiating the process of licensee closure for one of one resident (R1) reviewed.. This had the potential to affect all residents who resided at the facility. 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: Review of MDH documentation on April 17, 2023,	01240			

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01240	Continued From page 6 indicated MDH had no record the licensee provided notification MDH the licensee was closing. On May 25, 2022, the licensee's assisted living licensure was approved for renewal per MDH. On April 17, 2023, the MDH investigator arrived at the licensee at approximately 11:22 a.m. and no one answered the licensee's front door. The licensee had no cars or activity, and the facility appeared vacant. A phone call was made to the licensee and the phone number was no longer in service. On April 17, 2023, at approximately 12:13 p.m., the MDH investigator arrived at the licensee's corporate offices. The office door contained a sign that indicated office hours for this date would be from 10:00 a.m. to 5:00 p.m. No one answered the corporate office door. During an interview on April 17, 2023, at 3:45 p.m., with the licensed assisted living director/owner, (LALD)-B stated the licensee had closed the licensee effective as of May 5, 2022, and all paperwork had been turned in to the state agency for closure. LALD-B also stated in this same interview, that the licensee was in litigation and the licensee's attorney had all documents pertaining to the licensee and advised the licensee not to give the documents to anyone. No further information provided. TIME PERIOD FOR CORRECTION: Two (2) Days	01240		

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01260	Continued From page 7	01260		
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 must also provide this information to the resident's case manager. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to provide the ombudsman of long-term care, designated resident representatives, and case managers, a written closure notification at least 60 calendar days before initiating the licensee closure and also failed to provide documentation to the Minnesota Department of Health (MDH). This had the potential to affect the 1 resident (R1) who recieved services from the licensee. 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	01260		

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01260	Continued From page 8 or has the potential to affect a large portion or all of the residents). Findings Include: Review of MDH documentation on April 17, 2023, indicated MDH had no record the licensee provided notification to MDH that the licensee was closing. On May 25, 2022, the licensee's assisted living licensure was approved for renewal per MDH. An email provided on April 20, 2023, at 12:31 p.m., by R1's case manager, (SW)-A, indicated she was never notified of the licensee closure at any time. An email was provided on April 20, 2023, at 2:36 p.m., by R1's guardian (FM)-C, indicated FM-C received a letter of closure on June 16, 2022, at 8:53 a.m. from the licensee's operations manager, (ADM)-E. This letter to FM-C, indicated R1's case manager, who was no longer employed at the time, was informed of the licensee closure on May 15, 2022, via a letter of closure. During an interview on April 17, 2023 at 3:45 p.m., with the licensed assisted living director/owner, (LALD)-B stated the licensee had closed the licensee effective as of May 5, 2022, and all paperwork had been turned in to the state agency for closure. LALD-B also stated in this same interview that the licensee was in litigation and the licensee's attorney had all documents pertaining to the licensee and advised the licensee not to give the documents to anyone. During an interview on April 17, 2023, at 4:49 p.m., SW-A stated her organization was notified by the county of which the licensee's corporate	01260			

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01260	Continued From page 9 offices are located, that the licensee was under an investigation and this letter was dated May 13, 2022, and sent to SW-A's department on approximately June 2, 2022. During an interview on April 18, 2023, at 4:09 p.m. and April 20, 2023, at 9:43 a.m., FM-C stated on approximately June 16, 2022, he received notice from the licensee's county, that the licensee's licensure was going to be suspended. FM-C then stated he called the licensee on June 16, 2022, to inquire about the licensure suspension and was informed by the licensee's staff member that FM-C had approximately one week to find new placement for R1 due to licensee closure. During an interview on April 20, 2023, at 3:58 p.m., R1's mental health case worker, (SW)-D, stated she was not notified of the facility closing until FM-C informed her after R1 was in the hospital awaiting new placement. No further information provided. TIME PERIOD FOR CORRECTION: Two (2) Days	01260		