STATE LICENSING COMPLIANCE REPORT

Report #: HL344324597C

Date Concluded: March 25, 2024

Name, Address, and County of Facility Investigated:
Jabez Customized Living
1417 Brookdale Drive North
Brooklyn Park, MN 55444
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Holly German, 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
	34432	A. BUILDING: _____ B. WING _____	C 02/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JABEZ CUSTOMIZED LIVING SERVICES	1417 BROOKDALE DRIVE BROOKLYN PARK, MN 55444

(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: #HL344324597C On February 28, 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 3 residents receiving services under the provider's Assisted Living Care license. The following correction order is issued for #HL344324597C, tag identification 470.	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.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470		

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0 470	Continued From page 1 determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview, observation, and document review the licensee failed to ensure staff were scheduled and present onsite 24 hours per day, seven days per week for 3 of 3 residents reviewed. In addition, the licensee failed to have a written staffing plan developed by the clinical nurse supervisor. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 470		

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0 470	Continued From page 2 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 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: R1's diagnosis included schizophrenia and amputation of toe. R1's received medication management and meal preparation services. R2's diagnosis included morbid obesity and sleep apnea. R2's received medication management and meal preparation services. R3's diagnosis included diabetes and hypertension. R3's received medication and meal preparation services. Licensee provided document titled "Uniform Disclosure of Assisted Living Services and Amenities" dated April 1, 2022, indicated unlicensed staff were to be in the building and available to respond to resident requests 24 hours a day, seven days a week. Licensee provided document titled "August 2023 Staff Schedule-1417" indicated there was no staff scheduled at the facility for various amounts of time for six days in the month of August 2023. Law enforcement report dated August 6, 2023, at 07:47 a.m. indicated law enforcement officers arrived to the facility in response to a medical call placed by a resident and there was no staff present onsite.	0 470		

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0 470	Continued From page 3 Licensee provided document titled "SEPT 2023 Staff Schedule-1417" indicated there was no staff scheduled at the facility for various amounts of time for 11 days in the month of September 2023. Licensee provided document titled "FEB 2024 Staff Schedule-1417" indicated there was no staff scheduled at the facility from 4:00 p.m. to 10:00 p.m. on February 28, 2024. On February 28, 2024, at 08:10 a.m. the investigator arrived at the facility and rang the doorbell multiple times in attempt to gain access in to the facility. The facility door remained locked securely by digital keypad. Additionally, the investigator knocked on the door of the facility multiple times with no answer. At 08:26 a.m. a vehicle pulled in to the driveway of the facility, and the driver identified self as licensed assisted living director (LALD)-A. LALD-A confirmed there was not staff in the facility at that moment, because she had left to get a soda. In email communication on March 7, 2024, at 2:11 p.m., LALD-A stated she did not have a formal staffing plan. LALD-A stated she has staff coverage on a disclosure form that she orients all employees to. During an interview on March 4, 2024, at 2:00 p.m., resident (R1) stated staff do not check on her often, and sometimes there is not a staff member in the building. R1 stated LALD-A can be very rude and unprofessional to residents and staff. During an interview on March 4, 2024, at 2:25 p.m., unlicensed staff member (ULP)-B stated LALD-A removed all of ULP-B's overnight shifts after ULP-B told LALD-A she could not work one	0 470		

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0 470	Continued From page 4 of the days LALD-A wanted her to work. ULP-B stated LALD-A was rude to staff and would argue with staff. During an interview on March 5th, 2024, at 3:00 p.m., ULP-C stated there was times there was not staff scheduled in the building on overnight shifts because LALD-A had cameras to monitor the facility from. ULP-C stated LALD-A was rude to staff, so staff would quit. During an interview on March 7, 2024, at 9:00 a.m., LALD-A stated the facility currently employed three caregivers which includes herself. LALD-A stated she ended the employment of ULP-B because the cost of her salary was a hardship on the business. LALD-A stated she was looking to hire more staff with method of word of mouth because advertising, such as Indeed, were too expensive. LALD-A stated the facility always has staff onsite, but there are times she leaves to take a resident to an appointment. LALD-A stated if the schedule does not always show staff in the facility, it would be due to typos. Additionally, LALD-A stated she had directed the residents to call her if they need something when there was not staff in the facility. LALD-A stated she assessed the residents for home alone time to ensure the amount of time that was safe for residents to be home alone. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		