STATE LICENSING COMPLIANCE REPORT

Report #: HL346235163C

Date Concluded:

Name, Address, and County of Facility Investigated:
Essence Care Center
Robland Home Health Care
963 21at Street SE
Rochester, MN 55904

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

Evaluator's Name: Brooke Anderson, 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
	34623	A. BUILDING: _____ B. WING _____	C 09/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENCE CARE CENTER	963 21ST STREET SE ROCHESTER, MN 55904

(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: #HL346232709C #HL346235163C On September 18, 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 2 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued/orders are issued for ##HL346232709C and #HL346235163C, tag identification 0250, 0990, 2240.	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	

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0 000	Continued From page 1	0 000	ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 250 SS=D	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	0 250		

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0 250	Continued From page 2 the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (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 observation, interview, and record review, the licensee failed to fully cooperate with an inspection, survey, or investigation as evidenced by failure comply with records requested. 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:	0 250		

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0 250	Continued From page 3 During an entrance conference on September 18, 2023, at 11:10 a.m., with registered nurse (RN)-B and social worker (SW)-C. Investigator advised licensee documents would be requested and the investigator would need the documents in a timely manner. RN-B stated licensed assisted living director (LALD)-A was out of the country, but LALD-A had his computer and RN-B could assist LALD-B in sending requested documents to investigator. In an email on September 18, 2023, at 9:17 a.m., assisted living director (LALD)-A was sent a request to provide facility records, In an email on September 19, 2023, at 10:00 p.m., RN-B sent R1's medical records and policies requested. In an email on September 20, 2023, at 9:17 a.m., investigator requested R1's signed bill of rights. The facility did comply with some record requests throughout the investigation but failed to provide the investigator with signed assisted living bill or rights as requested. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250		
0 990 SS=D	144G.52 Subd. 2 Prerequisite to termination of a contract (a) Before issuing a notice of termination of an assisted living contract, a facility must schedule and participate in a meeting with the resident and	0 990		

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0 990	Continued From page 4 the resident's legal representative and designated representative. The purposes of the meeting are to: (1) explain in detail the reasons for the proposed termination; and (2) identify and offer reasonable accommodations or modifications, interventions, or alternatives to avoid the termination or enable the resident to remain in the facility, including but not limited to securing services from another provider of the resident's choosing that may allow the resident to avoid the termination. A facility is not required to offer accommodations, modifications, interventions, or alternatives that fundamentally alter the nature of the operation of the facility. (b) The meeting must be scheduled to take place at least seven days before a notice of termination is issued. The facility must make reasonable efforts to ensure that the resident, legal representative, and designated representative are able to attend the meeting. (c) The facility must notify the resident that the resident may invite family members, relevant health professionals, a representative of the Office of Ombudsman for Long-Term Care, a representative of the Office of Ombudsman for Mental Health and Developmental Disabilities, or other persons of the resident's choosing to participate in the meeting. For residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the facility must notify the resident's case manager of the meeting. (d) In the event of an emergency relocation under subdivision 9, where the facility intends to issue a notice of termination and an in-person meeting is impractical or impossible, the facility must use telephone, video, or other electronic means to conduct and participate in the meeting required	0 990		

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0 990	Continued From page 5 under this subdivision and rules within Minnesota Rules, chapter 4659. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to schedule and hold a pre-termination meeting seven days before a notice of termination was issued for one of one resident (R1) reviewed. 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: R1's unsigned service plan dated September 5, 2023, indicated R1 received services which included medication management, meals, assistance with grooming, dressing, showers, and behavioral management. R1's care conference notes dated August 14, 2023, indicated a meeting was held with R1's family member, guardian, case worker, and the licensed assisted living director (LALD)-A. Concerns addressed at the care conference included R1's smoking, in addition to other concerns R1 had with the licensee. A review of email correspondence from the licensee to R1's guardian dated August 16, 2023, indicated, "therefore, after careful consideration	0 990		

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0 990	Continued From page 6 of the circumstances, we believe it is in everyone's best interest to issue a thirty-day notice of termination of R1's residence at our facility." The notice was provided two days following the care conference meeting. R1's discharge-transfer summary dated August 23, 2023, indicated the licensee did not feel R1 was appropriate for the facility and the licensee would not be receiving the resident back to the facility. No termination of services notice, and no contract termination notice were provided. During an interview on September 18, 2023, at 11:10 a.m., registered nurse (RN)-B stated, regarding R1's discharge, R1 was admitted to the hospital and the licensee was told by a family member (FM-B) the facility could not call the hospital and could not obtain information from the hospital. It was obvious R1 would be discharged from the facility. The licensee did not provide a discharge policy. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 990		
02240 SS=D	144G.90 Subdivision 1 Assisted living bill of rights; notification (a) An assisted living facility must provide the resident a written notice of the rights under section 144G.91 before the initiation of services to that resident. The facility shall make all reasonable efforts to provide notice of the rights to the resident in a language the resident can understand.	02240		

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02240	Continued From page 7 (b) In addition to the text of the assisted living bill of rights in section 144G.91, the notice shall also contain the following statement describing how to file a complaint or report suspected abuse: "If you want to report suspected abuse, neglect, or financial exploitation, you may contact the Minnesota Adult Abuse Reporting Center (MAARC). If you have a complaint about the facility or person providing your services, you may contact the Office of Health Facility Complaints, Minnesota Department of Health. If you would like to request advocacy services, you may contact the Office of Ombudsman for Long-Term Care or the Office of Ombudsman for Mental Health and Developmental Disabilities." (c) The statement must include contact information for the Minnesota Adult Abuse Reporting Center and the telephone number, website address, email address, mailing address, and street address of the Office of Health Facility Complaints at the Minnesota Department of Health, the Office of Ombudsman for Long-Term Care, and the Office of Ombudsman for Mental Health and Developmental Disabilities. The statement must include the facility's name, address, email, telephone number, and name or title of the person at the facility to whom problems or complaints may be directed. It must also include a statement that the facility will not retaliate because of a complaint. (d) A facility must obtain written acknowledgment from the resident of the resident's receipt of the assisted living bill of rights or shall document why an acknowledgment cannot be obtained. Acknowledgment of receipt shall be retained in the resident's record. This MN Requirement is not met as evidenced by: Based on interview and record review, the	02240		

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02240	Continued From page 8 licensee failed to ensure the current Minnesota Bill of Rights for Assisted Living Residents was provided and a written acknowledgement was received for one of one resident (R1) 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, 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: R1 began receiving services under the assisted living licensee on August 7, 2023. R1's diagnoses included unspecified psychosis, depression, and alcohol use disorder. R1's unsigned service plan dated September 5, 2023, indicated R1 received services which included medication management, meals, assistance with grooming, dressing, showers, and behavioral management. R1's unsigned service plan dated September 5, 2023, included a section that indicated: I have received a copy of the following: Minnesota Bill of Rights for Assisted Living Residents ***My signature below indicates that I received copies of the above listed documents.	02240		

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02240	Continued From page 9 R1's service plan lacked a signature acknowledging R1 received a copy of the Minnesota Bill of Rights for Assisted Living Residents. During email communication on September 20, 2023, at 9:17 a.m., the investigator requested the licensee to provide a copy of the signed Assisted Living Bill of Rights or documentation R1 received the Assisted Living Bill of Rights upon admission to the facility. The licensee did not provide the Minnesota Assisted Living Bill of Rights when requested. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02240		