STATE LICENSING COMPLIANCE REPORT

Report #: HL348174667C

Date Concluded: January 11, 2023

Name, Address, and County of Facility Investigated:
Royal Caring Hands HHC Services
5548 Logan Ave North
Brooklyn Center , MN 55430
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Erin Johnson-Crosby, 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
	34817	A. BUILDING: _____ B. WING _____	C 01/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL CARINGHANDS HHC SERVICES	5548 LOGAN AVENUE NORTH BROOKLYN CENTER, MN 55430

(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 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: HL348174667C On January 4, 2023, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. The following correction orders are issued for HL348174667C, tag identification 1040, 1070 and 1110.	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.	
01040 SS=D	144G.52 Subd. 7 Notice of contract termination required	01040		

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01040	Continued From page 1 (a) A facility terminating a contract must issue a written notice of termination according to this section. The facility must also send a copy of the termination notice to the Office of Ombudsman for Long-Term Care and, for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, to the resident's case manager, as soon as practicable after providing notice to the resident. A facility may terminate an assisted living contract only as permitted under subdivisions 3, 4, and 5. (b) A facility terminating a contract under subdivision 3 or 4 must provide a written termination notice at least 30 days before the effective date of the termination to the resident, legal representative, and designated representative. (c) A facility terminating a contract under subdivision 5 must provide a written termination notice at least 15 days before the effective date of the termination to the resident, legal representative, and designated representative. (d) If a resident moves out of a facility or cancels services received from the facility, nothing in this section prohibits a facility from enforcing against the resident any notice periods with which the resident must comply under the assisted living contract. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to issue a written notice for a termination of contract at least 30 days ahead of the termination, or at least 15 days ahead of an expedited termination, and failed to provide documentation supporting the need for an expedited termination of their contracts for one of one (R1) former resident with records reviewed.	01040		

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01040	Continued From page 2 R1's contract was terminated without notice after being sent to the hospital. 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 discharge summary from the previous facility dated June 15, 2022, indicated R1 required a high level of behavioral support. The summary indicated R1's refusals of medications, appointments and interfering behaviors have made living in a residential setting very difficult. R1 would become verbally and physically aggressive with staff and other residents. R1 had thrown television remotes, phones and personal property at staff when agitated. R1 has hit, shoved, and kicked staff and may posture at staff in a threatening manner when requests are not met. R1 would also call 911 at inappropriate times. R1 visited the emergency room 200 times in the last year. The summary also indicated R1 would elope and run down the street towards traffic and exit moving vehicles. R1 was admitted to the licensee on June 15, 2022, with diagnoses that included schizophrenia, bipolar disorder, anxiety and depression. R1's care plan dated June 15, 2022, indicated R1 received services for medication management, meals, laundry, housekeeping, and supervision for grooming and dressing. The service plan also	01040		

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01040	Continued From page 3 indicated R1 had a history of verbal and physical abuse with staff when staff say no. R1 also had a history of elopement and frequent calls to 911. R1's individual abuse prevention plan (IAPP) dated June 15, 2022, indicated R1 was at risk for elopement and required monitoring. R1 also was physically aggressive at times and required supervision. An email dated September 4, 2022, sent by the administrator indicated on September 3, 2022, R1 threatened to call adult protection, became belligerent, and threatened to hit the administrator. R1 then grabbed a cup full of water and poured it on the computer and keyboard and knocked over the computer monitor. The administrator called 911. R1 then again threatened the administrator when R1 stated "I could break your head with this", while holding the phone. The officers responded and the administrator pleaded for the officers to take R1 to the hospital. The officers took R1 to the hospital. An email dated September 6, 2022, sent by the administrator indicated R1's behaviors lately were endangering himself and others and a meeting was requested to attempt to alleviate the problem. An email dated September 9, 2022, sent by the administrator to R1's guardian, case manager and others identified on September 8, 2022, R1 was aggressive that morning. R1 requested money but R1 did not have any money. R1 grabbed a cup of coffee sitting on the dining table and attempted to pour it on the computer keyboard. The administrator attempted to stop and stood between the keyboard and R1. R1 then	01040		

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01040	Continued From page 4 started moving towards the television. R1 threatened to throw the coffee mug at the administrator. The administrator was fearful of getting injured or killed and called 911. When officers arrived R1 was calm. The officers left without taking R1. The email also indicated at 3:45 p.m., R1 had another mental outburst and R1 called 911 himself. R1 told the officers he was having suicidal thoughts and was brought to the emergency room by police. R1's progress notes dated September 15, 2022, indicated R1 had increased aggression with the administrator on September 8, 2022. R1 was taken to the hospital and would not be returning to the facility. R1's discharge summary dated September 15, 2022, indicated R1 was sent to the hospital on September 8, 2022, for increased violence and aggression. R1 also threatened the administrator and staff. R1 was not able to return due to increased violence. R1's Notice of Emergency Relocation and Notice of an Expedited Termination of an Assisted Living Contract dated September 21, 2022, indicated R1 was removed from the licensee on September 9, 2022 on an emergency relocation. The document indicated a meeting was conducted on September 8, 2022, to discuss effective termination of R1's contract. R1 was not happy about the meeting, left the room and called 911. The licensee chose not to take him back from the hospital due to psychotic outbursts, elopement and endangering himself and others. On January 6, 2023, at 1:25 p.m., administrator-A stated the licensee was aware of R1's history of verbal and physical aggression and elopements.	01040		

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01040	Continued From page 5 Administrator-A stated the licensee assumed R1 had improved since R1 was at a crisis center before admission. Administrator-A stated "we learned our lesson the hard way and are now being more careful on the residents that are admitted." Administrator-A stated R1 was sent to the hospital on September 9, 2022, was not allowed to return and the notice of expedited termination was not sent to R1, the guardian or others involved in R1's care until September 21, 2022. The licensee's undated Notice of Termination policy, indicated a notice notice of an expedited contract termination will be issued to the resident, the resident's legal representative and the resident's designated representative at least 15 days before the effective date or termination. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01040		
01070 SS=D	144G.52 Subd. 10 Right to return If a resident is absent from a facility for any reason, including an emergency relocation, the facility shall not refuse to allow a resident to return if a termination of housing has not been effectuated. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee infringed upon a resident's right to return to the facility following an emergency relocation without providing a written notice of termination for one of one (R1) residents reviewed. This practice resulted in a level two violation (a	01070		

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01070	Continued From page 6 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 discharge summary from the previous facility dated June 15, 2022, indicated R1 required a high level of behavioral support. The summary indicated R1's refusals of medications, appointments and interfering behaviors made living in a residential setting very difficult. R1 would become verbally and physically aggressive with staff and other residents. R1 had thrown television remotes, phones and personal property at staff when agitated. R1 has hit, shoved and kicked staff and may posture at staff in a threatening manner when requests are not met. R1 would also call 911 at inappropriate times. R1 visited the emergency room 200 times in the last year. The summary also indicated R1 would elope and run down the street towards traffic and exit moving vehicles. R1 was admitted to the licensee on June 15, 2022, with diagnoses that included schizophrenia, bipolar disorder, anxiety and depression. R1's care plan dated June 15, 2022, indicated R1 received services for medication management, meals, laundry, housekeeping, and supervision for grooming and dressing. The service plan also indicated R1 had a history of verbal and physical abuse with staff when staff say no. R1 also had a history of elopement and frequent calls to 911.	01070		

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01070	Continued From page 7 R1's individual abuse prevention plan (IAPP) dated June 15, 2022, indicated R1 was at risk for elopement and required monitoring. R1 also was physically aggressive at times and required supervision. R1's progress notes dated September 15, 2022, indicated R1 had increased aggression with the administrator on September 8, 2022. R1 was taken to the hospital and would not be returning to the facility. R1's discharge summary dated September 15, 2022, indicated R1 was sent to the hospital on September 8, 2022, for increased violence and aggression. R1 also threatened the administrator and staff. R1 was not able to return due to increased violence. An email dated September 4, 2022, sent by the administrator indicated on September 3, 2022, R1 threatened to call adult protection, became belligerent, and threatened to hit the administrator. R1 then grabbed a cup full of water and poured it on the computer and keyboard and knocked over the computer monitor. The administrator called 911. R1 then again threatened the administrator when R1 stated "I could break your head with this", while holding the phone. The officers responded and the administrator pleaded for the officers to take R1 to the hospital. The officer took R1 to the hospital. An email dated September 6, 2022, sent by the administrator indicated R1's behaviors lately were endangering himself and others and a meeting was requested to attempt to alleviate the problem. An email dated September 9, 2022, sent by the	01070		

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01070	Continued From page 8 administrator to R1's guardian, case manager and others identified on September 8, 2022, R1 was aggressive that morning. R1 requested money but R1 did not have any money. R1 grabbed a cup of coffee sitting on the dining table and attempted to pour it on the computer keyboard. The administrator attempted to stop and stood between the keyboard and R1. R1 then started moving towards the television. R1 threatened to throw the coffee mug at the administrator. The administrator was fearful of getting injured or killed and called 911. When officers arrived R1 was calm. The officers left without taking R1. The email also indicated at 3:45 p.m., R1 had another mental outburst and R1 called 911. R1 told the officers he was having suicidal thoughts and was brought to the emergency room by police. R1's Notice of Emergency Relocation and Notice of an Expedited Termination of an Assisted Living Contract, dated September 21, 2022, indicated R1 was removed from the licensee on September 8, 2022 on an emergency relocation. The document indicated a meeting was conducted on September 8, 2022, to discuss effective termination of R1's contract. R1 was not happy about the meeting, left the room, and called 911. The licensee chose not to take him back from the hospital due to psychotic outbursts, elopement, and endangering himself and others. On January 6, 2023, at 1:25 p.m., administrator-A stated the licensee was aware of R1's history of verbal and physical aggression and elopements upon admission. Administrator-A stated the licensee assumed R1 had improved since R1 was at a crisis center before admission. Administrator-A stated "we learned our lesson the hard way and are now being more careful on the	01070		

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01070	Continued From page 9 residents that are admitted. Administrator-A stated R1 was sent to the hospital on September 8, 2022, and was not allowed to return, and confirmed and expedited termination notice was not provided to R1 until September 21, 2022. On January 9, 2022, at 9:00 a.m., R1's waiver case manager (CM)-B stated R1 went to the hospital on September 8, 2022, and the licensee did not allow R1 to return. CM-B stated R1 had to stay at the hospital for approximately 10 days. CM-B stated R1 did not meet admission criteria for the hospital but there was not a safe discharge plan for R1 so the hospital let him stay. The licensee's undated Emergency Relocation policy, indicated if the licensee refuses to provide housing or services to the resident, this would trigger the termination of services process. If the licensee has not terminated the services after relocation, it will not impede the resident's right to return to the facility. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01070		
01110 SS=D	144G.55 Subdivision 1 Duties of facility (a) If a facility terminates an assisted living contract, reduces services to the extent that a resident needs to move, or conducts a planned closure under section 144G.57, the facility: (1) must ensure, subject to paragraph (c), a coordinated move to a safe location that is appropriate for the resident and that is identified by the facility prior to any hearing under section 144G.54; (2) must ensure a coordinated move of the resident to an appropriate service provider	01110		

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01110	Continued From page 10 identified by the facility prior to any hearing under section 144G.54, provided services are still needed and desired by the resident; and (3) must consult and cooperate with the resident, legal representative, designated representative, case manager for a resident who receives home and community-based waiver services under chapter 256S and section 256B.49, relevant health professionals, and any other persons of the resident's choosing to make arrangements to move the resident, including consideration of the resident's goals. (b) A facility may satisfy the requirements of paragraph (a), clauses (1) and (2), by moving the resident to a different location within the same facility, if appropriate for the resident. (c) A resident may decline to move to the location the facility identifies or to accept services from a service provider the facility identifies, and may choose instead to move to a location of the resident's choosing or receive services from a service provider of the resident's choosing within the timeline prescribed in the termination notice. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to ensure a coordinated move to an appropriate location identified by the facility prior to a termination hearing and failed to consult and cooperate with the resident and case manager to make arrangements to move the resident for one of one (R1) residents 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	01110		

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01110	Continued From page 11 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 discharge summary from the previous facility dated June 15, 2022, indicated R1 required a high level of behavioral support. R1's refusals of medications, appointments and interfering behaviors have made living in a residential setting very difficult. R1 would become verbally and physically aggressive with staff and other resident. R1 had thrown television remotes, phones and personal property at staff when agitated. R1 has hit, shoved and kicked staff and may posture at staff in a threatening manner when requests are not met. R1 would also call 911 at inappropriate times. R1 visited the emergency room 200 times in the last year. The summary also indicated R1 would elope and run down the street towards traffic and exit moving vehicles. R1 was admitted to the licensee on June 15, 2022, with diagnoses that included schizophrenia, bipolar disorder, anxiety and depression. R1's care plan dated June 15, 2022, indicated R1 received services for medication management, meals, laundry, housekeeping, and supervision for grooming and dressing. The service plan also indicated R1 had a history of verbal and physical abuse with staff when staff say no. R1 also had a history of elopement and frequent calls to 911. R1's individual abuse prevention plan (IAPP) dated June 15, 2022, indicated R1 was at risk for elopement and required monitoring. R1 also was physically aggressive at times and required supervision.	01110		

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01110	Continued From page 12 An email dated September 4, 2022, sent by the administrator indicated on September 3, 2022, R1 threatened to call adult protection, became belligerent, and threatened to hit the administrator. R1 then grabbed a cup full of water and poured it on the computer and keyboard and knocked over the computer monitor. The administrator called 911. R1 then again threatened the administrator when R1 stated "I could break your head with this", while holding the phone. The officers responded and the administrator pleaded for the officers to take R1 to the hospital. The officer did take R1 to the hospital. An email dated September 6, 2022, sent by the administrator indicated R1's behaviors lately were endangering himself and others and a meeting was requested to attempt to alleviate the problem. An email dated September 9, 2022, sent by the administrator to R1's guardian, case manager and others identified on September 8, 2022, R1 was aggressive that morning. R1 requested money but R1 did not have any money. R1 grabbed a cup of coffee sitting on the dining table and attempted to pour it on the computer keyboard. The administrator attempted to stop and stood between the keyboard and R1. R1 then started moving towards the television. R1 threatened to throw the coffee mug at the administrator. The administrator was fearful of getting injured or killed and called 911. When officers arrived R1 was calm. The officers left without taking R1. The email also indicated at 3:45 p.m., R1 had another mental outburst and R1 called 911. R1 told the officers he was having suicidal thoughts. R1 was brought to the	01110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34817	A. BUILDING: _____ B. WING _____	C 01/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01110	Continued From page 13 emergency room. R1's progress notes dated September 15, 2022, indicated R1 had increased aggression with the administrator on September 8, 2022. R1 was taken to the hospital and would not be returning to the facility. R1's discharge summary dated September 15, 2022, indicated R1 was sent to the hospital on September 8, 2022, for increased violence and aggression. R1 also threatened the administrator and staff. R1 was not able to return due to increased violence. R1's Notice of Emergency Relocation and Notice of an Expedited Termination of an Assisted Living Contract and dated September 21, 2022, indicated R1 was removed from the licensee on September 8, 2022 on an emergency relocation. The document indicated a termination meeting was conducted on September 8, 2022, to discuss effective termination of R1's contract. R1 was not happy about the meeting, left and called 911. The licensee decided not to take him back form the hospital due to psychotic outbursts, elopement and endangering himself and others. On January 6, 2023, at 1:25 p.m., administrator-A stated the licensee was aware of R1's history of verbal and physical aggression and elopements. Administrator-A stated the licensee assumed R1 had improved since R1 was at a crisis center before admission. Administrator-A stated R1 was sent to the hospital on September 8, 2022, and was not allowed to return. Administrator-A stated "we learned our lesson the hard way and are now being more careful on the residents that are admitted."	01110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01110	Continued From page 14 On January 9, 2022, at 9:00 a.m., R1's waiver case manager (CM)-B stated R1 went to the hospital on September 8, 2022, and the licensee did not allow R1 to return. CM-B stated R1 had to stay at the hospital for approximately 10 days due to the refusal of the facility to allow R1 to return. CM-B stated R1 did not meet admission criteria for the hospital but there was not a safe or coordianated discharge plan for R1 so he remained in the hospital for 10 days until new placement could be found. The licensee's undated Notice of Termination policy, indicated a notice notice of an expedited contract termination will be issued to the resident, the resident's legal representative and the resident's designated representative at least 15 days before the effective date or termination. The licensee's undated Emergency Relocation policy, indicated if the licensee refuses to provide housing or services to the resident, this would trigger the termination of services process. If the licensee has not terminated the services after relocation, it will not impede the residents right to return to the facility. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01110		