STATE LICENSING COMPLIANCE REPORT

Report #: HL353153541C **Date Concluded: August 8, 2024**

Name, Address, and County of Facility Investigated:
Hands Care LLP
1065 Dennis Street South
Maplewood, MN 55119
Ramsey County

Facility Type: Assisted Living Facility (ALF) **Evaluator's Name:** Lori Pokela
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 (for ALL). 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
	35315	A. BUILDING: _____ B. WING _____	C 06/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HANDS CARE LLP	1065 DENNIS STREET SOUTH MAPLEWOOD, MN 55119

(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: #HL353153541C On June 25, 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 three residents receiving services under the provider's Assisted Living license. The following correction order is issued/orders are issued for #HL353153541C , tag identification 2350.	0 000		
02350 SS=D	144G.91 Subd. 7 Courteous treatment Residents have the right to be treated with courtesy and respect, and to have the resident's property treated with respect	02350		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35315	A. BUILDING: _____ B. WING _____	C 06/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HANDS CARE LLP	1065 DENNIS STREET SOUTH MAPLEWOOD, MN 55119

(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
02350	Continued From page 1 This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to treat one of one resident (R1) with courtesy and respect when staff forced R1 to shower after R1 refused cares. 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 medical record was reviewed. R1 was admitted to the licensee on April 16, 2024. R1's diagnoses included diabetes mellitus type II, atrial fibrillation, hepatic stenosis and major depressive disorder. R1's service plan dated, indicated R1 received daily stand-by (SBAS) assistance with hygiene, as needed (PRN) SBA with bathing, daily staff assist with medication administration, including blood sugar checks, insulin injections, safety checks and as needed (PRN) stand-by assistance with transfers. R1's 14-day nursing assessment dated April 19, 2024, indicated R1 wore incontinent briefs occasionally for bowel and received staff assist with incontinent bowel PRN. This assessment indicated R1 used a cane with stand-by assistance (SBA), assistance with locating food, and monitor behaviors. R1's nursing assessment	02350	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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35315	A. BUILDING: _____ B. WING _____	C 06/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HANDS CARE LLP	1065 DENNIS STREET SOUTH MAPLEWOOD, MN 55119

(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
02350	Continued From page 2 lacked documentation that R1 was legally blind. R1's initial Individual Abuse Prevention Plan (IAPP), dated April 16, 2024, indicated R1 had a history of substance abuse, was legally blind, had an unstable gait and used the cane. This IAPP indicated R1 would remain in familiar surroundings and remain safe due to vision deficits. R1's progress note dated April 22, 2024,(time not indicated], indicted R1 had loose stools in the bathroom and when staff was trying to clean R1, R1 was screaming, kicking at staff. Staff were able to clean R1 up. A licensee incident report dated April 22, 2024 at 2:00 p.m., indicated when R1 had loose stools, R1 spit at staff and banging the walls when they were trying to give cares. A pretermination letter dated April 24, 2024, by registered nurse, licensed assisted living director, (LALD)-A, indicated R1 requested to use the bathroom and had loose stool all over and refused staff assistance. This document indicated the licensee had three staff members assist with R1's shower while R1 yelled: "you have no right over me, get me out of here, I do not need you guys to help, fuck you, I can take care of myself!" A complaint report dated April 30, 2024 at 5:23 p.m., indicated R1 was forced to take a shower when he refused. This reported indicated R1 felt very uncomfortable being touched in the shower and staff would not listen then staff would insist they needed to assist with R1's shower so he would not fall. An email dated July 10, 2024 at 8:29 p.m.,	02350	REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35315	A. BUILDING: _____ B. WING _____	C 06/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HANDS CARE LLP	1065 DENNIS STREET SOUTH MAPLEWOOD, MN 55119

(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
02350	Continued From page 3 LALD-A responded to the investigator's as to why staff would clean R1 if he did not want to be cleaned? LALD-A responded with: " R1 is legally blind with neuropathy and does not feel when his poop is coming down." " I don't want to be rude, but what would you do?" "Leave the resident walking around contaminating the whole place?" During an interview dated July 10, 2024 at 3:33 p.m., R1 stated licensee staff refused to let me shower independently and would shower me. R1 stated he recalled, one time he had an accident and the licensee staff forced me to take a shower. There were three of them. The three tried pushing me while I held on to a pole, then one of them was hitting me while I held that pole. R1 stated he was behavioral because he felt uncomfortable with the licensee's staff touching him while he was naked. During an interview dated July 12, 2024 at 8:41 a.m., ULP-D stated she recalled one time when it took two staff members to give R1 a shower. ULP-D stated staff would try to talk to R1 to get him to shower but when R1 refused it took two staff members. ULP-D stated R1 would hold on to the shower fighting and swearing. ULP-D stated R1 had a loose BM and told staff he did not need to shower after having the loose BM but we had to intervene. The licensee provided Resident Bill of Rights Policy dated August 2022, indicated: (2) Refusal of Care: Residents have the right to refuse care or assisted living services. (3) Courteous Treatment: Residents have the right to be treated with courtesy and respect. No further information was provided.	02350		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35315	A. BUILDING: _____ B. WING _____	C 06/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HANDS CARE LLP	1065 DENNIS STREET SOUTH MAPLEWOOD, MN 55119

(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
02350	Continued From page 4 TIME PERIOD FOR CORRECTION: Seven (7) days	02350		