Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL356989005M
Compliance #: HL356986567C

Date Concluded: April 16, 2024

Name, Address, and County of Licensee Investigated:
Graceful Lodge Home Care
6430 June Avenue North
Brooklyn Center, MN, 55429
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Angela Vatalaro, RN
Special Investigator

Finding: Substantiated, facility responsibility

Nature of Investigation:
The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

Initial Investigation Allegation(s):
The facility neglected the resident when they failed to provide the resident appropriate supervision. The resident left the facility and went missing.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. Facility staff were aware the resident had used methamphetamine (illegal stimulant), not slept for several days, was hallucinating, and impaired the night the resident left the facility. Facility staff did not file a missing person report with law enforcement until 30 hours after the resident eloped while impaired. The resident was found drowned two days later in a body of water.

The investigator conducted interviews with facility staff members, including administrative staff and unlicensed staff. The investigation included review of the resident's record, death record,

facility internal investigation, facility incident report, law enforcement reports, and related facility policy and procedures. Also, the investigator toured the facility.

The resident resided in an assisted living facility. The resident's diagnoses included schizophrenia, alcohol abuse, and stimulant (methamphetamine) use disorder. The resident's service plan included assistance with medication management, mental health management, including managing agitation, physical aggression, verbal aggression, resistive tendencies, self-isolation, depression, and anxiety.

The residents medical record indicated the resident was alert, oriented, and coherent. The resident had a history of leaving the facility to pan handle (ask for money from the public) and polysubstance use (alcohol and methamphetamine abuse.) The resident had a history of suicide attempts and staff were directed to monitor for suicidal ideation, document, report any changes in mood and behavior to the nurse, and contact 911 if the resident reported suicidal ideation. The resident used illicit drugs/chemicals which resulted in altered perceptions of reality and in-appropriate decision making. The resident had a history of wandering and leaving the facility without informing staff and staff were directed to always monitor the resident's whereabouts while the resident was awake. Staff were directed to monitor the resident for any substance use while in the facility, severe side effects of intoxication, and to contact the registered nurse when the resident exhibited severe side effects of intoxication. The residents medical record failed to identify specific side effects of alcohol and drug use staff should monitor for and report to the registered nurse.

The residents medical record indicated, "For about four days now, [resident] had been walking up and down the driveway talking to himself due to a substance used." Staff came at 11:00 p.m., and the resident was lying on the grass in the back yard. Staff went outside and suggested the resident come in the house to get some rest, but the resident said he was fine in the grass. At 3:00 a.m. the resident told staff, "When I am lying on my bed, I see a lot of people and spirits tell me, you are going to be fine." The resident left the facility at 3:30 a.m. and had not returned.

The resident's record did not include evidence staff contacted the registered nurse about the resident's changes in behavior, known substance use, being awake for days, or that the resident left the facility while impaired.

The law enforcement report indicated a missing person report was made by the facility approximately 30 hours after the resident left the facility. The facility reported the resident was schizophrenic, was off his medications, and suffered from anxiety. Two days later, law enforcement learned another law enforcement agency found the resident's deceased in a body of water.

The resident's death records indicated the resident's cause of death was apparent freshwater drowning. Other significant conditions contributing to the resident's death included recent

methamphetamine use, history of multi-substance use disorders, anxiety, depression, and schizophrenia. The manner of death could not be determined.

During an interview, unlicensed personnel (ULP) stated the resident had eloped and went missing during the overnight shift. The ULP worked the previous shift, and the resident was impaired because the resident would “talk, talk, talk,” was “up and down” would be “all over” and was unable to go to sleep. The ULP stated when the resident was on drugs the staff would talk to resident, tell him it was “ok,” tell the resident to get sleep, or leave the resident alone. Daily, the resident left the facility to panhandle and upon return, the resident was intoxicated on alcohol. The ULP stated the resident left the facility while impaired and would leave multiple times throughout the day. The ULP stated she did not contact the registered nurse about the resident’s behaviors and side effects of alcohol and drugs.

During an interview, another ULP stated the day the resident eloped, she worked the overnight shift. The ULP stated when the resident used (unknown substance), the resident would not sleep for days and would continuously talk until the drugs got of his system. During shift, the resident was on the lawn for hours in the back yard. The ULP stated earlier in the shift, the resident had told the ULP he saw “spirits” that talked to him. The ULP stated she checked on resident at 2:00 a.m., and resident said he was “ok.” Two hours later, the ULP said she listened through the resident’s room door, did not hear sounds, and thought the resident was sleeping. Three hours after that, the ULP knocked on the resident’s door for breakfast and the resident was not there. The ULP stated she did not notify the nurse the resident had been up for days, taken substances, and made comments about seeing spirits.

During an interview, leadership stated the resident talked to himself whenever he was under the influence of alcohol and/or drugs. The resident left the facility to panhandle any time of the day and night and would go out in the middle of the night. It was not unusual for the resident to be gone two to three days at time. At times when the resident left the facility staff would have no idea where the resident went. Leadership stated when the resident used alcohol and/or illegal drugs, staff encouraged the resident to rest, and staff usually stayed away from the resident because of the resident’s physical aggression while using substances or drugs. Leadership stated staff monitored the resident when the resident dozed off, to watch his breathing. Leadership stated when a resident went missing the facility policy was to call 911 immediately. Leadership stated they did not call 911 immediately for the resident because the resident had left before for one or two days at time and had previously returned.

In conclusion, the Minnesota Department of Health determined neglect was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
“Substantiated” means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17

“Neglect” means neglect by a caregiver or self-neglect.
(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.

Vulnerable Adult interviewed: No, resident was deceased.
Family/Responsible Party interviewed: No, attempted but did not reach.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility notified the resident’s family the resident was missing and notified law enforcement approximately 30 hours after the resident left the facility.

Action taken by the Minnesota Department of Health:
The responsible party will be notified of their right to appeal the maltreatment finding.

The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

You may also call 651-201-4200 to receive a copy via mail or email.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Hennepin County Attorney
Brooklyn Center City Attorney
Brooklyn Center Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35698	A. BUILDING: _____ B. WING _____	C 03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACEFUL LODGE HOME CARE	6430 JUNE AVENUE NORTH BROOKLYN CENTER, MN 55429

(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: #HL356989005M/#HL356986567C #HL356984908C On March 14, 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 4 residents receiving services under the provider's Assisted Living license. The following correction orders are issued for #HL356989005M/ #HL356986567C, tag identification 2310, 2360. The following correction order is issued issued for #HL356984908C, tag identification 1130.	0 000		
01130 SS=G	144G.55 Subd. 2 Safe location A safe location is not a private home where the	01130		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35698	A. BUILDING: _____ B. WING _____	C 03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACEFUL LODGE HOME CARE	6430 JUNE AVENUE NORTH BROOKLYN CENTER, MN 55429

(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
01130	Continued From page 1 occupant is unwilling or unable to care for the resident, a homeless shelter, a hotel, or a motel. A facility may not terminate a resident's housing or services if the resident will, as the result of the termination, become homeless, as that term is defined in section 116L.361, subdivision 5, or if an adequate and safe discharge location or adequate and needed service provider has not been identified. This subdivision does not preclude a resident from declining to move to the location the facility identifies. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a safe discharge location or ensure an adequate and needed service provider was identified for one of one resident (R2) with records reviewed. R2 was discharged to a family member's home without verifying an assessment was performed with R2's family member and their home to determine whether R2's family member could meet R2's needs. R2 was wheelchair bound and dependent on others to complete most of R2's activities of daily living, including catheter care and wound care. This had the potential to lead to serious injury, impairment, or death for R2 when he was left at a family member's home without the family member present and no means for R2 to enter and exit the home. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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	01130	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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35698	A. BUILDING: _____ B. WING _____	C 03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACEFUL LODGE HOME CARE	6430 JUNE AVENUE NORTH BROOKLYN CENTER, MN 55429

(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
01130	Continued From page 2 situation has occurred only occasionally). The findings include: Minnesota (MN) Statute 144G.55, Subd. 2, Safe Location. A safe location is not a private home where the occupant is unwilling or unable to care for the resident, a homeless shelter, a hotel, or a motel. A facility may not terminate a resident's housing or services if the resident will, as a result of the termination, become homeless, as that term is defined in section 116L.361, Subd. 5, or if an adequate and unsafe discharge location or adequate and needed service provider has not been identified. R2's medical record indicated R2 was admitted to the facility on August 3, 2023. R2's with diagnoses that included paraplegia (paralysis of the lower extremities), type 1 diabetes, and ADHD (attention deficit hyperactivity disorder.) R2's service plan dated August 8, 2023, indicated R2 received daily assistance with medication management, blood glucose checks four times daily, incontinence care, management of agitation, anxiety, physical aggression, property destruction, repetitive behavior, resistive tendencies, self-injurious behaviors, verbal aggression, wound care twice daily, catheter care, transfer assistance, and toileting services. R2's Admission Assessment dated August 8, 2023, indicated R2 required assist of two staff for transfers using a mechanical lift. R2 was paralyzed from the waist down and was wheelchair-bound. R2 was able to move his upper body and extremities and could maneuver his manual wheelchair. R2 required one to two staff assist to transfer from bed to wheelchair, or	01130	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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35698	A. BUILDING: _____ B. WING _____	C 03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACEFUL LODGE HOME CARE	6430 JUNE AVENUE NORTH BROOKLYN CENTER, MN 55429

(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
01130	Continued From page 3 wheelchair to bed. R2 had a stage 4 pressure ulcer (full thickness tissue loss with exposed bone, tendon, or muscle) of the left buttock, a stage 2 pressure ulcer (partial thickness of of the skin that presented as a shallow open ulcer with a red or pink wound bed) of the right hip and a stage 1 pressure ulcer (pressure related alteration of intact skin over a bony prominence) of the coccyx. R2 required wound care twice daily, catheter care, incontinence cares after each incontinent episode, and required repositioning every two hours with assistance of one to two staff. The same assessment indicated R2 needed total assist to evacuate in an emergency. R2's Summary of Pre-Termination Meeting dated August 8, 2023, indicated persons attending the meeting included licensed assisted living director (LALD)-A, R2's family member (FM)-D, and R2's case manager. Summary of the meeting indicated R2 stole two debit cards from the facility manager and made several transactions. In addition, staff from another facility in the neighborhood reported to the licensee's supervisor of suspicious activity of R2 after hours when they witnessed R2 navigating around cars in the neighbors driveways after hours. Also, R2 left the facility nightly at odd hours for two to three hours between the hours of 11:00 p.m., and 2:00 a.m. The facility indicated they had concerns for R2's safety and his state of vulnerability. The meeting was held, and R2 was given a "second chance" to remain at the facility with required positive behavior support. R2's challenging behaviors included going out late at night for hours while being confined in a wheelchair, smoking "weed" in the facility, theft at the facility, theft in the community, and anger management. The facility had action items for theft mitigation	01130		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35698	A. BUILDING: _____ B. WING _____	C 03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACEFUL LODGE HOME CARE	6430 JUNE AVENUE NORTH BROOKLYN CENTER, MN 55429

(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
01130	Continued From page 4 techniques, probation officer interventions, and LALD-A requested full disclosure of reasons for R2's involuntary discharge from the last group home R2 was at. R2's Notice of Termination of Contact dated August 11, 2023, indicated R2 was provided an expedited assisted living contract termination and was required to vacate the property by August 26, 2023. Determining factors in the decision indicated the following: -A physical assault of a co-resident, continuous taunting and intimidation of the resident, verbal threats of potential assault to the co-resident with a cognitive deficit. -Continuous violation of the facility's smoke free zone and smoking cannabis (weed) within the zone -Repeated stealing of debit and credit cards of staff, making unauthorized charges on these cards, and stealing cards from the pocketbook of staff. -Trespassing on the properties of neighbors, alleged attempts to break in their cars. -Meeting of his associates (total of 4 persons) at 1:20 a.m., on the back deck of the facility. R2's facility discharge summary dated August 25, 2023, indicated R2's services were terminated August 19, 2023, which was earlier than the scheduled termination date of August 31, 2023. LALD-A brought R2 to his family member's home. The reason for R2's discharge included R2 engaged in financial fraud against staff members for the third time in two weeks. "The facility decided to immediately terminate R2's services by taking him to FM-D's home." Summary of R2's stay indicated R2 stayed at the facility for 16 days. The licensee documented "Each of those	01130		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35698	A. BUILDING: _____ B. WING _____	C 03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACEFUL LODGE HOME CARE	6430 JUNE AVENUE NORTH BROOKLYN CENTER, MN 55429

(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
01130	Continued From page 5 days was packed with one form of anxiety or trauma or another. He has engaged in too many physical and verbal aggressions and too many attempts of breaking into neighbors' vehicles. Importantly, we were extremely concerned about late night outings. He would go out between 11 p.m. to 12 a.m. and do no [sic] return until 2:00 to 3:00 a.m. We were respectful of his independence, but we were worried nightly about his current limitations (muscle spasm, fluctuating blood sugar and wheelchair bound). We tried second chances to continue to give him care at Graceful Lodge but his no [sic] ready to comply." R2's record lacked evidence the licensee completed an assessment with FM-D and their residence to ensure the FM-D could meet R2's needs and services. R2's record lacked evidence the move to FM-D's home was R2's informed choice. During an interview on March 26, 2024, at 1:36 p.m., LALD-A stated the licensee did not provide a notice to the Office of Ombudsman for Long-Term Care of R2's pretermination meeting on August 8, 2023, or R2's Notice of Contract Termination on August 11, 2023. LALD-A stated during R2's stay R2 had assaulted another resident and 911 was called. R2 also went into the neighborhood at 11:00 to 12:00 a.m. and would not return until 2:00 to 3:00 a.m. LALD-A said the group homes next door reported R2 broke into their cars, and homeowners across the street also reported R2 was found in their yard breaking into a car. R2 invited his "gang" to the facility at 1:00 a.m. to 2:00 a.m. and they would congregate on the back deck and causing disruptions. LALD-A stated they were concerned R2 could be seriously injured or die while under the care of the licensee and said they were	01130		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35698	A. BUILDING: _____ B. WING _____	C 03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACEFUL LODGE HOME CARE	6430 JUNE AVENUE NORTH BROOKLYN CENTER, MN 55429

(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
01130	Continued From page 6 concerned for R2's personal safety. The pretermination meeting was held and action items were planned. On August 8, 2023, the licensee did not conclude R2 would be discharged, LALD-A stated they wanted to continue to try to work with R2. When the licensee provided the notice for an expedited termination of contract, R2 had no planned location to discharge. After an additional theft of debit/credit card, LALD-A stated he called FM-D and told her R2 would not be able to stay at the facility as discussed and R2 would be brought to her home. FM-D had reservations and was hesitant about R2 being brought to FM-D's home. R2's case worker was attempting to secure alternative placement however, did not find placement before R2 was discharged. On August 19, 2023, LALD-A stated he called and spoke to FM-D and told her he was coming to drop R2 off. FM-D told LALD-A she was not home and would be home later. LALD-A stated he drove R2 to FM-D's home in the company van. R2's siblings were at home but not FM-D. The siblings would not allow R2 into the home because FM-D was not home and shut the door. LALD-A attempted to call FM-D again however, she did not answer. LALD-A stated they waited around outside until R2's siblings agreed to open the door. LALD-A and another staff lifted R2 into the home. FM-D's home did not have a wheelchair ramp making it inaccessible for R2 to enter or leave the home. LALD-A stated he believed it would be difficult for R2's case manager to find R2 other placement. LALD-A stated he felt "comfortable" dropping R2 off at FM-D's home as a safe location for discharge. The licensee policy titled, Contract Termination, dated August 10, 2022, indicated the licensee would participate in a coordinated transfer of care for the resident to another provider, or caregiver.	01130		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35698	A. BUILDING: _____ B. WING _____	C 03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACEFUL LODGE HOME CARE	6430 JUNE AVENUE NORTH BROOKLYN CENTER, MN 55429

(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
01130	Continued From page 7 TIME PERIOD TO CORRECT: Seven (7) days.	01130		
02310 SS=J	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide appropriate care and services based on resident's needs, according to an up-to date service plan and accepted health care standards, for one of one resident (R1) who had a history of alcohol abuse and methamphetamine (illegal stimulant) use and leaving the facility for extended periods of time. In addition, the licensee failed to follow their missing resident plan after R1 left the facility. Harm occurred when R1 eloped while impaired and was found drowned in a body of water. This practice resulted in a level four violation (a violation that results in serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of clients 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 indicated R1's diagnoses included schizophrenia, alcohol abuse, and	02310	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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35698	A. BUILDING: _____ B. WING _____	C 03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACEFUL LODGE HOME CARE	6430 JUNE AVENUE NORTH BROOKLYN CENTER, MN 55429

(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
02310	Continued From page 8 stimulant use disorder. R1's signed service plan dated August 19, 2021, indicated R1's services included medication management, mental health management, including managing agitation, physical aggression, verbal aggression, resistive tendencies, self-isolation, depression, and anxiety. R1's assessment dated September 9, 2023, indicated R1 was alert, oriented, and coherent. R1 had a history of leaving the facility to pan handle (ask for money from the public) and polysubstance use (alcohol and methamphetamine abuse.) R1 had a history of suicide attempts. Staff were directed to monitor for suicidal ideation, document, report any changes in mood and behavior to the nurse, and contact 911 if R1 reported suicidal ideation. R1's Individual Abuse Prevention Plan dated September 9, 2023, indicated R1 had a history of alcohol intoxication and elopement most often to pan handle in the street. When R1 used illicit drugs/chemicals, R1's perceptions of reality and appropriate decision making were affected. R1 had a history of wandering and would leave the facility without informing staff. Staff were to always monitor R1's whereabouts while awake. Facility staff were directed to monitor R1 for any substance use while in the facility, severe side effects of intoxication, and directed to contact the RN when R1 exhibited severe side effects of intoxication. The abuse prevention plan did not include specific side effects of alcohol and drug use that staff should report to the RN. R1's care plan dated September 9, 2023, identified R1 at risk of elopement and wandering.	02310	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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35698	A. BUILDING: _____ B. WING _____	C 03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACEFUL LODGE HOME CARE	6430 JUNE AVENUE NORTH BROOKLYN CENTER, MN 55429

(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
02310	Continued From page 9 The plan indicated staff would report to family, the RN, the case worker, and police if R1 was gone from the facility for 24 hours. R1's progress notes dated September 9, 2023, at 3:38 p.m. indicated R1 returned to the facility at 3:37 p.m., intoxicated, "very drunk" and vomited in R1's room. There was no documentation staff notified the RN of R1's intoxication with side effects. R1's progress notes dated September 10, 2023, at 2:48 p.m. indicated R1 was drinking in the common area of the facility from a bottle of vodka. When asked to stop drinking, R1 called staff offensive names. R1 left the facility and returned the next morning at 2:30 a.m. "so dunk [drunk] accusing staff of stealing his cigarettes and phone. R1 vomited in the trash. There was no documentation staff notified the RN of R1's intoxication with side effects. R1's progress notes dated September 11, 2023, at 12:27 p.m. indicated R1 came to the facility intoxicated, threw a plate of food, and vomited in a bathroom sink and "all over in his room". Staff suggested R1 go to the hospital but R1 told staff he was "simply suffering from a hangover". There was no documentation staff notified the RN of R1's physical status and side effects from intoxication. R1's progress notes dated September 11, 2023, at 10:06 p.m. indicated R1 left the facility at 3:30 p.m. and returned to the facility "drunk". R1 swore at staff, hit the refrigerator and "couldn't even stand". There was no documentation staff notified the RN of R1's physical status and side effects of intoxication.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35698	A. BUILDING: _____ B. WING _____	C 03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACEFUL LODGE HOME CARE	6430 JUNE AVENUE NORTH BROOKLYN CENTER, MN 55429

(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
02310	Continued From page 10 R1's progress notes dated September 28, 2023, indicated R1 was intoxicated. R1 left the facility at 2:30 a.m. and returned at 6:00 a.m. R1 was mixing juice and alcohol and drinking throughout the day. R1's weekly nursing visit progress notes dated September 29, 2023, revealed R1 had been drinking "lots" of alcohol, coming home intoxicated. Staff were directed to continue to monitor R1 for alcohol and drug abuse every shift and contact the RN or 911 for any apparent severe side effects of alcohol or drug intoxication. The progress note failed to identify the side effects staff should report to the RN. R1's progress notes dated September 29, 2023, indicated R1 and a friend were intoxicated at the facility. Staff knocked on R1's room door and discovered two one-half full bottles of vodka. There was no documentation facility staff notified the RN of R1's intoxication. R1's progress notes dated September 30, 2023, indicated R1 and his friend were still "knocked out drunk" and had fallen asleep in R1's room. R1's friend lived in a group home a street away. Staff documented R1's friend "was not capable of going home under this condition." Staff confiscated a large bottle of vodka that was partially consumed. There was no documentation staff notified the RN of R1's intoxication. R1's progress notes dated September 30, 2023, indicated R1 was "very hot and hyperventilating from drinking alcohol" and "was sweating profusely." Facility staff lowered facility thermostat to 64 degrees. After one hour of the dropped temperature, R1 left the facility. At 9:00 p.m., R1 returned and was "still sweating and under the	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35698	A. BUILDING: _____ B. WING _____	C 03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACEFUL LODGE HOME CARE	6430 JUNE AVENUE NORTH BROOKLYN CENTER, MN 55429

(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
02310	Continued From page 11 influence." There was no documentation staff notified the RN of R1's status. R1's progress notes dated October 2, 2023, indicated R1 left the facility at 7:00 a.m. and returned at 6:20 p.m. R1 was shouting at staff because staff told R1 he could not bring liquor onto the premises. R1 had mixed vodka with juice. R1's progress notes dated October 3, 2023, indicated R1 was on the back porch when staff arrived. R1 had been wandering in and out of the facility "was breathing fast." Unlicensed staff documented they monitored R1 and "he is fine now." R1's weekly nursing progress notes dated October 6, 2023, stated R1 had been drinking "lots" of alcohol, coming home intoxicated, and staff where to monitor R1 for alcohol and drug abuse every shift. R1 had episodes of alcohol intoxication on September 28, 29, and 30, 2023 and staff were to continue to monitor for signs symptoms of alcohol withdrawal and severe side effects. Staff were to call 911 in case of an emergency. The progress note failed to identify the side effects staff should report to the RN. R1's progress notes dated October 7, 2023, indicated R1 had been "awake for hours" and continued talking to himself from midnight until 10:20 a.m. R1 was in and out of the house smoking, drinking large amounts of fruit punch, and was "just having a monologue (talking)" with himself. Staff documented this was "usually a result of R1 using a substance (methamphetamine) that kept him awake and blabbing for hours on end." R1 left the facility at 1:00 a.m., and came back at 2:25 a.m.,	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35698	A. BUILDING: _____ B. WING _____	C 03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACEFUL LODGE HOME CARE	6430 JUNE AVENUE NORTH BROOKLYN CENTER, MN 55429

(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
02310	Continued From page 12 wandering in and out of the facility. R1' progress notes dated October 8, 2023, indicated when staff arrived at 7:00 a.m., R1 was in his room talking to himself. R1 went to the back porch and walked back and forth talking "even louder to himself." The note stated, "For three days now, [R1] had been walking up and down talking to himself because of substance use." Staff will continue to monitor [R1] due to substance use." R1's record did not include evidence staff contacted the RN or 911 regarding R1's change in behavior, known substance use, and being awake for hours. R1's progress notes dated October 9, 2023, at 12:13 p.m. indicated R1 used an unknown substance, left the facility, and was hallucinating. The notes indicated "For about four days now, [R1] had been walking up and down the driveway talking to himself due to a substance used." When staff came the night before at 11:00 p.m., R1 was lying on the grass in the back yard. Staff went out and suggested R1 come in the house to get some rest. R1 said he was fine in the grass. At 3:00 a.m. R1 came up to the staff member and said, "When I am lying on my bed, I see a lot of people and spirits tell me, you are going to be fine." R1 left the facility at 3:30 a.m. and not returned. R1's incident report dated October 9, 2023, indicated R1 had been walking up and down the driveway for days talking to himself due to a substance used. When the night shift came in on October 8, 2023, at 11:00 p.m., R1 was lying on the grass in the backyard. Staff walked over to R1 and suggested he come into the house to get rest. R1 said he was fine on the grass. R1 came in at 12:00 a.m. and went in and out of the house	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35698	A. BUILDING: _____ B. WING _____	C 03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACEFUL LODGE HOME CARE	6430 JUNE AVENUE NORTH BROOKLYN CENTER, MN 55429

(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
02310	Continued From page 13 multiple times talking to himself. On October 9, 2023, at 3:00 a.m., R1 went to staff and said, "When I'm lying in bed, I see a lot of people and spirits telling me, you are going to be fine." R1 left the facility at 3:30 a.m. and not returned. R1's progress notes dated October 12, 2023, indicated a sheriff came to the facility to inform staff, R1 was found deceased in a pond. Camera footage was reviewed by the sheriff and recorded R1 leaving the facility October 9, 2023, at 3:20 a.m. Staff were informed R1's body had been found two days prior. The law enforcement report indicated they received a missing person report from the facility on October 10, 2023, at 10:03 a.m. (approximately 30 hours after R1 left the facility). The facility reported R1 was schizophrenic and had been off his medications and suffered from anxiety. On October 12, 2023, law enforcement learned that a different law enforcement agency found R1 deceased in a body of water. The other law enforcement agency report indicated R1 was last seen on October 9, 2023, at 3:20 a.m. observed on facility camera footage leaving the facility walking alone down the street. R1's death record indicated R1's body was found on October 11, 2023. R1's immediate cause of death was apparent freshwater drowning. Other significant conditions contributing to R1's death included recent methamphetamine use, history of multi-substance use disorders, anxiety, depression, and schizophrenia. R1's manner of death could not be determined. The toxicology report indicated R1 had methamphetamine in his system. During an interview on March 27, 2024, at 9:49	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35698	A. BUILDING: _____ B. WING _____	C 03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACEFUL LODGE HOME CARE	6430 JUNE AVENUE NORTH BROOKLYN CENTER, MN 55429

(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
02310	Continued From page 14 a.m., unlicensed personnel (ULP)-B stated R1 had eloped and went missing during the overnight shift, on October 9, 2023. ULP-B worked the day shift on October 8, 2023. During ULP-B's shift R1 was impaired and using an unknown substance. ULP-B stated she knew R1 was impaired because R1 displayed certain behaviors when on substances. ULP-B stated she did not know what specific drugs R1 used, however R1 would "talk, talk, talk," was "up and down" would be "all over" and was unable to go to sleep. During her shift, R1 told ULP-B he was cold, she offered R1 a jacket. R1 removed the jacket saying he was "hot." ULP-B stated the staff would talk to R1, tell him it was "ok" tell R1 to get sleep, or leave R1 alone. Daily, R1 left the facility to panhandle and upon return, R1 would be intoxicated on alcohol. ULP-B stated R1 left the facility while impaired and would leave multiple times throughout the day. At times staff would not know when R1 left or where he went. ULP-B did not contact the RN with R1's behaviors and side effects of alcohol and drugs. During an interview on March 26, 2024, at 11:19 a.m., ULP-C, who identified as the manager, stated the day R1 eloped, she worked the overnight shift. The licensee staff knew R1 was on drugs and impaired when R1 left the facility. Whenever R1 used (unknown substance), R1 would not sleep for days and would continuously talk until the drugs got of his system. R1 had been up for two to three days talking to himself. During shift, R1 was on the lawn for hours in the back yard. ULP-C told R1 to come inside to get something to eat, drink, and rest. R1 told ULP-C he was fine outside. ULP-C provided R1 a comforter to keep him warm because it was cold outside. Earlier in the shift, R1 told ULP-B he has saw "spirits" that talked to him. The "spirits" told	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35698	A. BUILDING: _____ B. WING _____	C 03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACEFUL LODGE HOME CARE	6430 JUNE AVENUE NORTH BROOKLYN CENTER, MN 55429

(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
02310	Continued From page 15 R1 he was going to be alright. ULP-C, said she told R1 there were no spirits, told R1 he was going to be alright, and to rest. ULP-C said she checked on R1 at 2:00 a.m., and R1 said he was "ok." At 4:00 a.m., ULP-C listened through R1's room door, did not hear sounds, thought R1 was sleeping. Around 7:00 a.m., she knocked on R1's door for breakfast, R1 was not inside. During shift, ULP-C stated she did not contact the RN to let the nurse know R1 had been up for days, was on substances, made a comment about seeing spirits, and eloped. During an interview on March 26, 2024, 11:54 a.m., licensed assisted living director (LALD)-A stated R1 talked to himself whenever he was under the influence of alcohol and/or drugs. R1 left the licensee to panhandle any time of the day and night would go out at 2:00 a.m. or 3:00 a.m. It was not unusual for R1 to be gone two to three days at time. Sometimes LALD-A stated R1 had disposable needles and rubber in his room that he used as a tourniquet to tie his upper arm. LALD-A stated when R1 used alcohol and/or illegal drugs, staff encouraged R1 to rest, and staff usually stayed away from R1 because of R1's physical aggression while using substances or drugs. LALD-A stated staff monitored R1 when he dozed off, and if so, they watched R1's breathing. LALD-A stated when a resident went missing the facility policy was to call 911 immediately. LALD-A stated they did not call 911 immediately for R1 because R1's history of leaving for one or two days at time and R1 had previously returned. Minnesota Rules, Part 4659.0110. Subp.2 indicated a facility must develop and follow a missing resident plan that includes at least the following:	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35698	A. BUILDING: _____ B. WING _____	C 03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACEFUL LODGE HOME CARE	6430 JUNE AVENUE NORTH BROOKLYN CENTER, MN 55429

(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
02310	Continued From page 16 -identify a staff member for each shift who was responsible for implementing the missing resident plan, and ensure at least one staff member who was responsible for implementing the missing-resident plan was on site 24 hours a day, seven days a week -require that staff alert the staff member identified immediately if it was suspected that a resident may be missing; -identify staff by position description who were responsible for searching for missing residents or suspected missing residents; -require that staff conduct an immediate and thorough search of the facility, the facility's premises, and the immediate neighborhood in each direction when a resident was suspected to be missing; -require that a suspected missing resident be considered missing if the resident was not located after staff completed the search -require that staff immediately notify local law enforcement when a facility determines that a resident was missing; -require that staff cooperate with local law enforcement and provide any information that was necessary to identify and locate the missing resident. -When a resident was missing or was suspected missing, a facility's implementation of a missing resident plan does not relieve the facility of its obligation to provide assisted living services and appropriate care to all residents in the facility according to each resident's service plan, assisted living contract, and the requirements of this chapter and Minnesota Statutes, chapter 144G. The licensee's policy titled Missing Resident, dated August 1, 2022, indicated any resident noted absent from the facility without prior	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35698	A. BUILDING: _____ B. WING _____	C 03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACEFUL LODGE HOME CARE	6430 JUNE AVENUE NORTH BROOKLYN CENTER, MN 55429

(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
02310	Continued From page 17 arrangement would be treated as missing. A designated staff member will promptly organize a local search of the building, and immediate vicinity (grounds/neighborhood in all directions) using available home health aides or managers, if onsite for assistance. If the resident was not located the designated staff person would immediately contact the Director and/or Clinical Nurse supervisor regarding the missing resident. The Director, Clinical Nurse Supervisor, or designee would notify law enforcement and details of the call should be recorded. The licensee's policy titled Resident Change in Condition or Need, dated August 1, 2022, indicated when change in condition or need are identified, a Registered Nurse would initiate a change in condition assessment. The assessment may be limited to only those issues where a change has been identified. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	02310		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident reviewed (R1) was free from maltreatment. Findings include:	02360	No plan of correction is required for this tag.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35698	A. BUILDING: _____ B. WING _____	C 03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACEFUL LODGE HOME CARE	6430 JUNE AVENUE NORTH BROOKLYN CENTER, MN 55429

(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
02360	Continued From page 18 The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		