# STATE LICENSING COMPLIANCE REPORT

**Report #:** HL362807724C

**Date Concluded:** April 29, 2024

**Name, Address, and County of Facility Investigated:**
Serenehands Home Care
5913 York Avenue North
Brooklyn Center, MN 55429
Hennepin County

**Facility Type:** Assisted Living Facility (ALF)

**Evaluator's Name:**
Katie Germann, 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 |
|---|---|---|---|
| | 36280 | A. BUILDING: _____ B. WING _____ | C 03/13/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| SERENEHANDS HOME HEALTH CARE | 5913 YORK AVENUE NORTH BROOKLYN CENTER, MN 55429 |

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| 0 000 | Initial Comments<br><br>******ATTENTION******<br><br>ASSISTED LIVING PROVIDER CORRECTION ORDER<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation.<br><br>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.<br><br>INITIAL COMMENTS:<br><br>#HL362807724C<br><br>On March 13, 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 0 residents receiving services under the provider's Assisted Living license.<br><br>The following correction orders are issued for #HL362807724C, tag identification 0470, 1060 | 0 000 | | |
| 0 470 SS=F | 144G.41 Subdivision 1 Minimum requirements<br><br>(11) develop and implement a staffing plan for determining its staffing level that:<br>(i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility;<br>(ii) ensures sufficient staffing at all times to meet | 0 470 | | |

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| 0 470 | Continued From page 1<br>the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and<br>(iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility;<br>(12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be:<br>(i) awake;<br>(ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time;<br>(iii) capable of communicating with residents;<br>(iv) capable of providing or summoning the appropriate assistance; and<br>(v) capable of following directions;<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review the licensee failed to ensure an adequate staffing plan was in place to provide care for 2 of 2 residents, R1 and R2, who resided at the facility.<br><br>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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). | 0 470 | | |

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| 0 470 | Continued From page 2<br>The findings include:<br><br>R1 was admitted to the facility on November 8, 2021, with diagnoses including vascular dementia and left sided weakness. R1 required assistance with bathing, dressing, feeding, hygiene, grooming, transfers, ambulation, meals, toileting, and medication administration.<br><br>R2 was admitted to the facility on September 8, 2021, with diagnoses including depressive disorder, generalized anxiety disorder, and traumatic brain injury. The facility provided assistance with bathing, hygiene, grooming, and medication administration.<br><br>During an interview on March 13, 2024 at 11:00 a.m., Administrator (Admin)-A stated on December 1, 2023, the facility did not have staff to provide care for residents R1 and R2 so the facility called 911 and sent R1 and R2 to the hospital until staff were available to staff the facility. On December 4, 2024, Admin-A called the hospital to ask for R1 and R2 to be sent back to the facility. Hospital staff told Admin-A R1 and R2 had been placed in different homes and would not be returning to the facility.<br><br>During interview on March 18, 2024 at 9:00 a.m., R2's cases manager, (CM)-B stated he was notified by the hospital on December 1, 2023, R2 was hospitalized and they had no reason to admit him. CM-B stated he needed to find R2 somewhere to go, and R2 sat in the hospital lobby for approximately four hours with no assistance, no access to food or drink, and no medications.<br><br>No staffing plan was provided by the facility. | 0 470 | | |

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| 0 470 | Continued From page 3<br><br>The facility's undated staffing policy, indicated "qualified employees will be scheduled to meet the facility needs of health care and operations". The policy also indicates "the staffing personnel has authority, or may delegate authority, to replace an employee with a temporary agency as needed".<br><br>Time period for Correction: Fourteen (14) days. | 0 470 | | |
| 01060 SS=F | 144G.52 Subd. 9 Emergency relocation<br><br>(a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination.<br>(b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum:<br>(1) the reason for the relocation;<br>(2) the name and contact information for the location to which the resident has been relocated and any new service provider;<br>(3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities;<br>(4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and<br>(5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. | 01060 | | |

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| 01060 | Continued From page 4<br><br>(c) The notice required under paragraph (b) must be delivered as soon as practicable to:<br>(1) the resident, legal representative, and designated representative;<br>(2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and<br>(3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days.<br>(d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to provide documentation showing urgent medical reasons or imminent risk existed prior to the transfer to the hospital for two of two residents, R1 and R2, who resided at the facility. R1 and R2 were transferred from the facility to the hospital due to lack of staffing at the facility.<br><br>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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).<br><br>Findings Include:<br><br>R1 was admitted to the facility on November 8, 2021, with diagnoses including vascular dementia | 01060 | | |

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| 01060 | Continued From page 5<br><br>and left sided weakness. R1 required assistance with bathing, dressing, feeding, hygiene, grooming, transfers, ambulation, meals, toileting, and medication administration.<br><br>R2 was admitted to the facility on September 8, 2021, with diagnoses including depressive disorder, generalized anxiety disorder, and traumatic brain injury. The facility provided assistance with bathing, hygiene, grooming, and medication administration.<br><br>A text message from Admin-A to R1's family member dated December 1, 2023, at 9:21 a.m. indicated, "Good morning, I wanted to let you know that due to staffing crisis all AL residents at the facility have been taken to the hospital. Please reach out to the facility program director with further questions".<br><br>An email dated December 6, 2023, at 9:51 a.m., from case manager (CM)-C to Admin-A indicated, "I am writing to confirm that R1 found a new home. I would like you to send me any discharge related paperwork, recent medical documentation, medication list, etc.".<br><br>During interview on March 13, 2024, at 11:00 a.m., Administrator (Admin)-A stated on December 1, 2023, the facility had no staff available to provide care for residents R1 and R2. Admin-A stated they made the decision to call 911 emergency services and send R1 and R2 to the hospital until the facility had staffing to provide care to th residents. Admin-A stated on December 4, 2023, they called the hospital to have R1 and R2 sent back to the facility. Hospital staff told Admin-A that R1 and R2 had been placed in different homes and would not be returning to the facility. | 01060 | | |

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| 01060 | Continued From page 6<br><br>In an interview on March 18, 2023, at 9:00 a.m., case manager (CM)-B stated R2 had to "sit in the emergency room" lobby for over four hours with no medications, no food or drink, and no knowledge of what was happening. CM-B was able to locate new housing for R2 later the same day.<br><br>The licensee lacked documentation providing a reason for the relocation, and a written notice providing the required minimums:<br>-reason for relocation;<br>-contact information for the Office of Ombudsman for Long-Term Care;<br>-if known and applicable, the approximate date or range of dates which the resident is expected to return to the facility, or a statement that a return date is not currently known;<br>-the notice under paragraph (b) must be delivered as soon as practicable to:<br>-the resident, legal representative, and designated representative;<br>-for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager;<br>-the Office of Ombudsman for Long-Term Care if the resident has been relocated.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Fourteen (14) days. | 01060 | | |