STATE LICENSING COMPLIANCE REPORT

Report #: HL366606779C

Date Concluded: March 7, 2024

Name, Address, and County of Facility Investigated:
Daniel Care Homes
6809 Perry Avenue North
Brooklyn Center, MN 55429

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
	36660	A. BUILDING: _____ B. WING _____	C 02/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANIEL CARE HOMES LLC	6809 PERRY 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: #HL366606779C On February 6, 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 order is issued for #H366606779C, tag identification 1040.	0 000		
01040 SS=D	144G.52 Subd. 7 Notice of contract termination required (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	01040		

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01040	Continued From page 1 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 resident, (R1) former resident with records reviewed. R1's contract was terminated without notice after being sent to the hospital. In addition, the licensee failed to send a copy of the termination notice to the Office of Ombudsman for Long Term Care.	01040		

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01040	Continued From page 2 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 was admitted to the licensee on October 25, 2022, with diagnoses including anxiety, attention deficit hyperactivity disorder, major depression, autism spectrum disorder, and fetal alcohol syndrome. R1's care plan dated October 25, 2022, indicated R1 received services for meals, housekeeping, laundry, and medication management. R1 also received assistance with behaviors of agitation, anxiety, elopement, and anger. R1's individual abuse prevention plan (IAPP) dated October 25, 2022, indicated R1 was at risk for harming himself and others physically through frequent outbursts resulting in property damage. Interventions included staff de-escalating the situation per the resident's behavior plan. No behavior plan was provided. R1's discharge-transfer summary dated October 25, 2023, indicated R1 was sent to the hospital on October 20, 2023, because he had "another major incident at the facility". The report indicated R1 would not be allowed back at the facility due to unsafe behavior toward others and repetitive self-harm. R1 had behaviors including major property destruction, verbal and physical	01040		

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01040	Continued From page 3 altercations with his housemates, and repetitive trips to the emergency room. The facility's notice of termination of assisted living contract, dated October 23, 2023, indicated the facility was planning an expedited termination due to R1's behaviors with his housemates interfering with the other residents' rights to health and safety in the facility. The notice indicated R1 held a pen in his hand and demonstrated how he would kill someone. R1 had also threatened to kill his roommate and his roommate's pet. R1 had recently requested to touch a female staff member and when she declined, R1 told the staff member, "if you touch me, I will not be violent". The staff member declined and R1 became physically violent causing property destruction. The notice indicates the other residents in the home informed staff they would not live there any longer if R1 returned to the facility. Hospital notes dated October 20, 2023, indicated R1 was feeling suicidal. The hospital notes indicate R1 had pneumonia and was treated. The hospital admitted R1, and he stayed in the emergency room for over a month while social services attempted to find him a place to live. R1's record did not include a termination notice to the Office of Ombudsman for Long Term Care. The licensee's Discharge and Transfer of Residents policy dated August 1, 2021, indicated a written 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.	01040		

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01040	Continued From page 4 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01040		