



STATE LICENSING COMPLIANCE REPORT

Report #: HL374479282C

Date Concluded: May 3, 2024

Name, Address, and County of Facility

Investigated:

Royal Home Care Inc
5745 Bossen Terrace
Minneapolis, MN 55417
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Barbara Axness, 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.

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37447	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/23/2024
NAME OF PROVIDER OR SUPPLIER ROYAL HOME CARE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 5745 BOSEN TERRACE MINNEAPOLIS, MN 55417		
(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	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>ASSISTED LIVING PROVIDER CORRECTION ORDER</p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation.</p> <p>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.</p> <p>INITIAL COMMENTS:</p> <p>#HL374479282C</p> <p>On April 23, 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 zero residents receiving services under the provider's Assisted Living license. The Assisted Living license was closed with an effective date of March 23, 2024.</p> <p>The following correction order is issued for #HL374479282C, tag identification 1050.</p>	0 000	<p>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 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.</p> <p>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.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p> <p>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.</p>	
01050 SS=D	144G.52 Subd. 8 Content of notice of termination	01050		
The notice required under subdivision 7 must contain, at a minimum:				

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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01050	<p>Continued From page 1</p> <p>(1) the effective date of the termination of the assisted living contract;</p> <p>(2) a detailed explanation of the basis for the termination, including the clinical or other supporting rationale;</p> <p>(3) a detailed explanation of the conditions under which a new or amended contract may be executed;</p> <p>(4) a statement that the resident has the right to appeal the termination by requesting a hearing, and information concerning the time frame within which the request must be submitted and the contact information for the agency to which the request must be submitted;</p> <p>(5) a statement that the facility must participate in a coordinated move to another provider or caregiver, as required under section 144G.55;</p> <p>(6) the name and contact information of the person employed by the facility with whom the resident may discuss the notice of termination;</p> <p>(7) information on how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities to request an advocate to assist regarding the termination;</p> <p>(8) information on how to contact the Senior LinkAge Line under section 256.975, subdivision 7, and an explanation that the Senior LinkAge Line may provide information about other available housing or service options; and</p> <p>(9) if the termination is only for services, a statement that the resident may remain in the facility and may secure any necessary services from another provider of the resident's choosing.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to provide a termination notice which contained all required information for one of one</p>	01050		

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01050	<p>Continued From page 2</p> <p>resident (R1) with records reviewed.</p> <p>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).</p> <p>The findings include:</p> <p>R1 admitted to the facility on December 10, 2023, from another facility owned by the licensee. R1 discharged on January 31, 2024.</p> <p>R1's diagnoses included schizophrenia, seizure disorder, bipolar disorder, psychotic episodes, paranoid disorder, major depressive disorder, and antisocial personality disorder.</p> <p>The service plan for R1 provided was not for the health facility identification (HFID) number of the facility but for a different facility owned by the licensee. The other facility's service plan dated February 17, 2023, indicated the resident received assistance with bathing, dressing, drinking, behavior management for agitation, anxiety, orientation issues, self isolation, suicidal tendencies, and depression, meal assistance, medication administration, blood glucose monitoring, and verbal and visual reminders.</p> <p>R1's progress notes lacked documentation of moving to a different facility. A progress note dated December 7, 2024, indicated "when staff arrived, [R1] was in his unit packing because he was moving out, the staff helped him throughout</p>	01050		

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01050	<p>Continued From page 3</p> <p>the shift moving his things..." A progress note dated January 20, 2024, indicated R1 was "in the next building packing his belongings because he will be moving soon..." Another note on January 31, 2024, indicated "staff helped him packing, at 12pm moving truck came and started putting [R1's] belongings in the truck..." The last progress note in the resident's record was entered on January 28, 2024, and did not include any documentation on where the resident moved to.</p> <p>R1's record contained a Cover Sheet for Notices from Assisted Living Facilities to the Office of Ombudsman for Long-Term Care dated December 1, 2023. The notice type selected was Change in Operations Resulting in Resident Transfer within Facility, despite the resident being transferred outside of the facility to a facility at a different address. The notice indicated the proposed transfer date was December 4, 2023, and the resident would be "moving to the campus next door...it is literally next to the 5749 Bossen Ter Minneapolis, where we are moving them from. This campus is right next door." The notice was signed by licensed assisted living director (LALD)-A</p> <p>LALD-A provided the investigator with various emails ranging from October 2023 to December 2023. The emails contained the following: On October 25, 2023, the resident's case manager emailed LALD-A to request a meeting to discuss "discuss the impact and implications of a license change will have on the MI&D person who are living at the Bossen Terrace Assisted Living apartments..." A meeting was set up with the case manager however, LALD-A did not log into the meeting. After various replies, the case manager requested to contact the licensor for the Minnesota Department of Health so they could</p>	01050		

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01050	<p>Continued From page 4</p> <p>ask them questions on the proposed change. LALD-A replied on November 14, 2023, writing, "I am not working with any Licenser about the changes; however, I have a solution to this issue at hand, I have another apartment building where they can reside and get the services they need. I will share more information on Thursday." LALD-A advised the case manager he had two places licensed as an integrated community setting that the resident could move to.</p> <p>An email sent by LALD-A to the case manager on January 10, 2024, indicated he would like to "schedule a meeting with you to do a predetermination meeting about the termination of contract that is coming up. It is a requirement by the statute. If you can let me know when you are available anytime this week, that will be great." R1's record lacked any follow up documentation on the meeting.</p> <p>R1's record did not include evidence the licensee issued a written notice of termination that contained:</p> <ul style="list-style-type: none"> (1) the effective date of the termination of the assisted living contract; (2) a detailed explanation of the basis for the termination, including the clinical or other supporting rationale; (3) a detailed explanation of the conditions under which a new or amended contract may be executed; (4) a statement that the resident has the right to appeal the termination by requesting a hearing, and information concerning the time frame within which the request must be submitted and the contact information for the agency to which the request must be submitted; (5) a statement that the facility must participate in a coordinated move to another provider or 	01050		

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01050	<p>Continued From page 5</p> <p>caregiver, as required under section 144G.55; (6) the name and contact information of the person employed by the facility with whom the resident may discuss the notice of termination; (7) information on how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities to request an advocate to assist regarding the termination; (8) information on how to contact the Senior LinkAge Line under section 256.975, subdivision 7, and an explanation that the Senior LinkAge Line may provide information about other available housing or service options; and (9) if the termination is only for services, a statement that the resident may remain in the facility and may secure any necessary services from another provider of the resident's choosing.</p> <p>On April 24, 2024, at 12:15 p.m., LALD-A stated when he moved R1 from one of his facilities to this facility, he was not aware of the appropriate process and that the two facilities would not be viewed as part of a campus. LALD-A stated he had planned on closing this assisted living facility license and did not plan to renew his license but R1 was unable to find alternative placement. LALD-A stated the resident was not forced to move and they worked with him to find another facility but confirmed the appropriate documentation was not maintained. LALD-A stated he renewed his assisted living license for the facility as the resident would still be under his care after the license had expired and "I did exactly what they [Minnesota Department of Health] asked me to do, even though I was going to shut down the business."</p> <p>No further information was provided.</p>	01050		

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01050	Continued From page 6 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	01050		