

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL392343345M
Compliance #: HL392343524C

Date Concluded: July 23, 2024

Name, Address, and County of Licensee

Investigated:

Diversity Home Care
3853 Kings Wood Court
Eagan, MN 55122
Dakota County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name:

Kathy Barnhardt 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 the alleged perpetrator (AP)#1 and AP#2 failed to assess and provide treatment for the resident's severely infected toes.

The facility abused a resident when they promoted a hostile and fearful culture where staff threatened the resident would be evicted from the facility for voicing concerns or opinions regarding preferences or rights.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined neglect was not substantiated. Law enforcement completed a safety check for the resident and arranged for a medical evaluation at a hospital. There were no medical issues with the resident's feet.

The Minnesota Department of Health determined abuse was substantiated. The facility was responsible for the maltreatment. The facility demonstrated retaliatory behavior by indicating

they would evict the resident from the facility if the resident reported suspected abuse to the state or police. The resident's rights were restricted by the facility causing the resident emotional distress.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's case manager, family, and physician. The investigation included review of the resident's medical records, employee records, staff charting, case management notes, law enforcement reports and facility policies.

The resident resided in an assisted living facility. The resident's diagnoses included right-sided stroke, aphasia (difficulty expressing or understanding speech), and traumatic brain injury. The resident was totally dependent on staff to complete all activities of daily living, required a gastrostomy tube (placed into the stomach for liquid nourishment and medication administration), catheter care, required a wheelchair for mobility, and transferred with a mechanical sling lift. The resident was non-verbal however, answered questions by nodding his head up and down for yes or shaking his head side-to-side for no. The resident had a very limited support network.

Several progress notes written over a period of weeks by unlicensed personnel indicated the resident had a great toe that was red, swollen, possibly infected and noted a large bruise on the resident's left thigh. Unlicensed personnel documented "staff press on the big toe and white puss came out". The same progress note indicated unlicensed personnel notified the licensed staff of the resident's changes. The facility lacked documentation of a registered nurse assessing the resident's change of condition or unexplained injury.

A police report indicated an officer was sent to the facility to conduct a welfare check on the resident. The officer observed the resident's feet and toes and noted the resident's feet appeared darker colored with a fungus present on his toenail. The officer asked the resident if he would like to be sent to the hospital and the resident responded yes by nodding his head.

The hospital record indicated the resident was assessed, and x-rays were taken of the resident's right ankle. The resident had no infection following the evaluation.

A progress note indicated the resident received a notice signed by AP2 indicating the facility policy for nighttime oral and hygiene cares were amended and the resident would need to have their oral and hygiene cares completed by 10:00 p.m. The letter indicated there would be no exceptions and the residents would not be allowed to ask for cares outside of assigned times. The letter indicated if the residents asked for cares outside of the assigned times they would be asked to leave and given a two-week notice to vacate the facility. The letter indicated the residents were not allowed to report their concerns to the police or the state or they would be given a two-week notice to vacate the facility premises. Additionally, facility administration entered a progress note indicating administration stated to the resident "there will be no

tolerance for discriminating and calling staff sweetie, honey or any other sexist name” when the resident was given the letter.

Another notice provided to the resident included facility visiting hours for all visitors was set for 10:00 a.m. to 6:00 p.m.

Progress notes written by unlicensed personnel indicated one of the resident’s family members visited the resident during and outside of the facilities visiting hours. Facility staff documented one of the family members was not honoring the scheduled visiting hours and often staff would prompt visitors to leave at 6:00 p.m. A licensed staff and administrator notified the residents representative by email the family member was disrupting the facility’s schedule and felt the family member performed actions that had the potential to cause harm to the resident. The resident’s guardian filed a court order to restrict the family member from visiting. The court order was served on the family member of concern and three other family members outlining restrictions for visitation and contact with the resident and facility. The resident was not consulted or informed about the restrictions until the court order was sent to four family members. A series of progress notes written by unlicensed personnel indicated the resident was agitated about the restrictions and one unlicensed personnel wrote she had apologized to the resident for the family’s visiting situation. Licensed personnel documented it was expected the resident was upset about the restrictions because the family member often came to visit.

A progress note written by unlicensed personnel indicated the resident was upset because “he can’t get what he wants”. The resident observed licensed staff removing a loveseat from his room without consulting the resident first and the resident was upset he was not consulted.

A progress note written by unlicensed personnel indicated they questioned the resident about tape “crumpled” around his gastrostomy tube. The resident was upset by the questioning and did not want to eat. Unlicensed personnel indicated the resident tried to move the staff’s hand away during feeding and the unlicensed personnel told the resident if he chose not to eat at that time, he would be “hungry x 2” and dinner would not be served until later.

Progress notes written by unlicensed personnel over a period of months indicated the resident was often agitated about bedtime schedules.

Progress notes written by unlicensed staff indicated the resident was agitated and angry when licensed staff forbid the resident from going outside. Progress notes indicated staff felt it was not warm enough and the resident was “forbid to go outside to prevent any illness”.

During an interview, the registered nurse stated facility staff had to make choices for the resident and decide what was best for his health care including going outside.

During an interview, leadership stated the facility had to set certain visiting hours from 10:00 a.m. to 6:00 p.m. because they have a business, and they cannot have people coming and going whenever they want to visit residents.

During an interview, the resident was asked if he was taken outside by staff and the resident shook his head no. The resident was asked if he wanted to go outside, and he nodded his head yes.

In conclusion, the Minnesota Department of Health determined neglect was not substantiated.

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

“Not Substantiated” means:

An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment did not occur.

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.

Abuse: Minnesota Statutes section 626.5572, subdivision 2.

"Abuse" means:

(a) An act against a vulnerable adult that constitutes a violation of an attempt to violate, or aiding and abetting a violation of:

- (1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224;
- (2) the use of drugs to injure or facilitate crime as defined in section 609.235;
- (3) the solicitation, inducement, and promotion of prostitution as defined in section 609.322; and
- (4) criminal sexual conduct in the first through fifth degrees as defined in sections 609.342 to 609.3451.

A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.

(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:

- (1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;
- (2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening.

Vulnerable Adult interviewed: Yes.

Family/Responsible Party interviewed: Yes.

Alleged Perpetrator interviewed: Yes both AP#1 and AP#2.

Action taken by facility:

No action taken by 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

Dakota County Attorney

Eagan City Attorney

Eagan Police Department

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39234	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/30/2024
NAME OF PROVIDER OR SUPPLIER DIVERSITY HOME CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3853 KINGS WOOD COURT EAGAN, MN 55122			
(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>#HL392341320M/ #HL392348725C #HL392343344M/ #HL392343523C #HL392343345M/ #HL392343524C #HL392343346M/ #HL392343525C</p> <p>On April 30, 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.</p> <p>The following correction orders are issued for #HL392341320M/#HL392348725C, #HL392343344M/#HL392343523C, #HL392343345M/#HL392343524C, and #HL392343346M/ #HL392343525C, tag identification 2290, 2360, 2380, 2400, and 2560.</p> <p>The following correction order is issued for</p>	0 000	<p>Assisted Living Provider 144G.</p> <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 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.</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. REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p> <p>THE LETTER IN THE THERE IS NO LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.</p>		

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39234	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 04/30/2024
NAME OF PROVIDER OR SUPPLIER DIVERSITY HOME CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3853 KINGS WOOD COURT EAGAN, MN 55122		
(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	Continued From page 1	0 000			
01640 SS=F	<p>#HL392343344M/#HL392343523C, #HL392343345M/#HL392343524C, and #HL392343346M/ #HL392343525C, tag identification 1640.</p> <p>144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to</p> <p>(a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan.</p> <p>(b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities.</p> <p>(c) The facility must implement and provide all services required by the current service plan.</p> <p>(d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable.</p> <p>(e) Staff providing services must be informed of the current written service plan.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to ensure a service plan was initiated and included all required content for three of four residents (R2, R3, R4), reviewed.</p> <p>This practice resulted in a level two violation (a</p>	01640			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39234	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/30/2024
NAME OF PROVIDER OR SUPPLIER DIVERSITY HOME CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3853 KINGS WOOD COURT EAGAN, MN 55122			
(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
01640	<p>Continued From page 2</p> <p>violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was 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).</p> <p>The findings include:</p> <p>R2's diagnoses included aphasia (loss of ability to understand or express speech) and multiple sclerosis.</p> <p>R2's assessment dated April 16, 2024, indicated R2 received services including assistance with medication management and administration, bathing, dressing, grooming, ambulation, transfers with assist of two staff with the use of a mechanical lift (mechanical device utilizing a body sling), incontinence cares and hydration assistance.</p> <p>R2 lacked a service plan to include all required content.</p> <p>R3's diagnosis included quadriparesis (weakness and diminished mobility in all limbs).</p> <p>R3's assessment dated April 28, 2024, indicated R3 received services including medication management and administration, bathing, dressing, feeding, hygiene, grooming, repositioning, transfers with assist of two staff with the use of a mechanical lift, ambulation assist, and incontinence cares.</p> <p>R3 lacked a service plan to include all required content.</p>	01640			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39234	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/30/2024
NAME OF PROVIDER OR SUPPLIER DIVERSITY HOME CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3853 KINGS WOOD COURT EAGAN, MN 55122			
(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
01640	<p>Continued From page 3</p> <p>R4's diagnoses included quadriplegia and traumatic brain injury.</p> <p>R4's assessment dated February 8, 2024, indicated R4 received services including assistance with medication management and administration, behavior management, bathing, dressing, grooming, feeding, ambulation, transfers with assist of two staff with the use of a mechanical lift, incontinence cares, nebulizer treatments, and management of a Foley catheter.</p> <p>R4 lacked a service plan to include all required content.</p> <p>On May 16, 2024 at 9:54 a.m., and May 20, 2024, at 7:41 a.m., signed service plans were requested for R2, R3 and R4. No service plans were provided for R2, R3 and R4.</p> <p>During interview on May 21, 2024 at 9:30 a.m. registered nurse (RN)-A stated R2, R3, and R4 did not have service plans completed by the facility.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Fourteen (14) days.</p>	01640			
02290 SS=F	<p>144G.91 Subd. 2 Legislative intent</p> <p>The rights established under this section for the benefit of residents do not limit any other rights available under law. No facility may request or require that any resident waive any of these rights at any time for any reason, including as a condition of admission to the facility.</p>	02290			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39234	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/30/2024
NAME OF PROVIDER OR SUPPLIER DIVERSITY HOME CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3853 KINGS WOOD COURT EAGAN, MN 55122		
(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
02290	<p>Continued From page 4</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee limited the rights of four of four residents (R1, R2, R3, R4) reviewed. The licensee limited visitors from 10:00 a.m. to 6:00 p.m. This practice affected all the residents living at the facility and their visitors.</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) and was 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).</p> <p>The findings include:</p> <p>R1 was admitted to the facility on November 11, 2022. R1's diagnoses included juvenile rheumatoid arthritis. R1 received assistance with medication administration, toileting, bathing, dressing, grooming, meals, transfers, housekeeping, and laundry.</p> <p>During an interview on April 30, 2024 at 10:40 a.m., R1 stated the facility amended visitation hours to be between 10:00 a.m. to 6:00 p.m., R1 stated the facility had a lot of rules and restrictions, and the resident could not have have visitors after 6:00 p.m.</p> <p>R2 was admitted to the facility on June 27, 2023. R2's diagnoses included functional quadriplegia (paralysis of all four limbs), dysphasia (difficulty swallowing), aphasia (loss of ability to express/understand speech), and major depressive disorder. R2 received assistance with</p>	02290			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39234	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/30/2024
NAME OF PROVIDER OR SUPPLIER DIVERSITY HOME CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3853 KINGS WOOD COURT EAGAN, MN 55122		
(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
02290	<p>Continued From page 5</p> <p>transfers, toileting, bathing, dressing, grooming, eating, medication administration, and ambulation.</p> <p>R3 was admitted to the facility on April 18, 2023. R3's diagnoses included quadriparesis (weakness of both arms and both legs), seizure disorder and bladder neurogenesis (lack of bladder control due to a brain, spinal cord, or nerve problem).</p> <p>R4 was admitted to the facility on January 10, 2023. R4's diagnoses included right-sided stroke, aphasia and traumatic brain injury.</p> <p>A progress note dated April 18, 2024, and written by Admin-D indicated R4 had a visit from his legal representative and R4 had been informed he had visitors that would no longer be allowed to visit. Admin-D wrote "we let [R4] know that if he does not like the decision that he can make the decision to go to the hospital or find a new home if he would like. He seemed to understand this and became less vocal after he was told this information".</p> <p>On April 30, 2024, at 12:13 p.m., registered nurse (RN)-A stated visiting hours were 10:00 p.m. to 6:00 p.m. because staff were busy, families snooped all over the place, and RN-A needed standard visiting hours.</p> <p>An undated resident handbook provided by the licensee included a policy titled U:Guests, and indicated, "The action and conduct of all guests are the responsibility of the resident. Please supervise and accompany your guests within the residence at all times. Also, be respectful that this is also your housemates' home and people have different schedules. With this in mind, if you are</p>	02290			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39234	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/30/2024
NAME OF PROVIDER OR SUPPLIER DIVERSITY HOME CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3853 KINGS WOOD COURT EAGAN, MN 55122		
(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
02290	Continued From page 6 expecting guests at any other times outside of 10:00 a.m. to 6:00 p.m., please speak with [facility name's] director of nursing (DON) or Business Manager for approval. [Facility name] reserves the right to ban any and all guests who come to [facility name] with intent to do harm or disturb staff or other residents at the facility or damage [facility name] property. We ask that you inform your visitor to sign in at the front desk and wear a "visitor" badge at all times while in residence". No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	02290			
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 four of four residents reviewed (R1, R2, R3 and R4) were free from maltreatment. The findings include: 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	02360	NO PLAN OF CORRECTION IS REQUIRED FOR THIS TAG.		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39234	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/30/2024
NAME OF PROVIDER OR SUPPLIER DIVERSITY HOME CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3853 KINGS WOOD COURT EAGAN, MN 55122		
(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 7 details.	02360			
02380 SS=I	144G.91 Subd. 10 Individual autonomy Residents have the right to individual autonomy, initiative, and independence in making life choices, including establishing a daily schedule and choosing with whom to interact. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to respect a resident's individual autonomy and choices when not allowing the resident the right to choose their own schedule, routines, times and methods of cares, getting up for the day or going to bed at night and ability to go outside for four of four residents (R1, R2, R3, R4). The licensee created a strictly controlled environment that stripped all residents of their ability to make individual choices in all facets of their daily lives. R1, R2, R3, and R4, were emotionally harmed when the facility threatened to evict the residents when the residents expressed individual preferences. 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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: R1, R2, R3, and R4's progress notes dated	02380			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39234	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/30/2024
NAME OF PROVIDER OR SUPPLIER DIVERSITY HOME CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3853 KINGS WOOD COURT EAGAN, MN 55122		
(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
02380	<p>Continued From page 8</p> <p>January 2, 2024, indicated the residents were given a memo regarding facility policies.</p> <p>Review of the undated memo provided to R1, R2, R3, and R4 indicated, "Our Policy for nighttime oral and hygiene care is being amended. All oral and hygiene evening care will be conducted by 10:00 p.m. There will be no exceptions. You will be able to go to bed whenever you like but unless your service plan is on you 6790 (county service plan) we will not be providing additional services at the times you demand. Calling out staff sweetie, honey or any other name other than their name is sexist and will not be tolerated. If demands and requests remain and do not go with our policy, you will be asked to leave and be given 2 weeks notice to vacate. Calling the police or state on our facility without proper cause will constitute an immediate 2 week notice to vacate our premises. We appreciate your cooperation."</p> <p>R1 was admitted to the facility on November 11, 2022. R1's diagnoses included juvenile rheumatoid arthritis and osteoarthritis of multiple joints with contracture (shortening, tightening of muscles, tendons, ligaments that can limit or prevent normal movement of a body part).</p> <p>R1's service plan dated November 17, 2022, indicated R1 received services to include: medication administration, bathing, dressing, grooming, hygiene, mobility assist, incontinence cares, behavior management, meal assist, and safety checks.</p> <p>R1's assessment dated February 25, 2024, indicated R1 received full assistance for dressing, grooming, bathing, and toileting. R1 required one person assistance with transfers, medication administration, toileting, bathing, dressing,</p>	02380			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39234	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/30/2024
NAME OF PROVIDER OR SUPPLIER DIVERSITY HOME CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3853 KINGS WOOD COURT EAGAN, MN 55122		
(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
02380	<p>Continued From page 9</p> <p>grooming, meals, transfers, housekeeping, and laundry. The assessment indicated R 1 was oriented to person, place, time, and situation, and independent in making his decisions. The assessment section labeled, "delusions" indicated R1 had "high expectation on staff." The assessment section labeled, "daytime sleeping pattern", indicated R1 preferred to go to sleep between the hours of 2:00 a.m. and 3:30 a.m., the section labeled, "evening sleeping pattern" indicated R1 went to bed "at 6:00 p.m." R1 would "watch movie and play video games until staff assist him to sleep at 2:00 a.m."</p> <p>R1's progress notes dated January 3, 2024, through April 30, 2024, indicated the following:</p> <ul style="list-style-type: none">- January 3, 2024, documented by unlicensed personnel (ULP)-G indicated R1 looked mad and upset. When R1 was asked how he was doing he stated, "I'm not doing so good. I don't want to tell you or else you will report to the RN."- January 4, 2024, documented by ULP-E indicated R1 stated he needed to follow the house rules and have grooming, and hygiene completed by 10:00 p.m. The progress note indicated the resident attempted to manipulate staff and the resident was attempting to explain his way of doing things, but R1 did not understand what is the "right fit" for his hygiene and bedtime.- January 5, 2024, documented by ULP-B indicated ULP-B "confronted" R1 about R1 "gossiping to other staff" about ULP-B's height.- January 11, 2024, documented by RN-A, indicated she spoke to R1's outside provider regarding the residents, "behavior." The note	02380			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39234	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/30/2024
NAME OF PROVIDER OR SUPPLIER DIVERSITY HOME CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3853 KINGS WOOD COURT EAGAN, MN 55122			
(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
02380	<p>Continued From page 10</p> <p>indicated the resident criticized and discriminated against staff, and R1 is a, "complainer and rambling nonsensical statement," and staff, "will not tolerate his demeanor."</p> <p>- February 18, 2024, documented by ULP-B indicated, R1 stated at the last place he lived he was able to have burgers, fries, hot dogs, and extra food. The note indicated R1 was, "criticizing us and not appreciating the care and healthy food here". ULP-B asked R1, "Why don't you want to live here anymore?" R1 responded, "I don't want to talk about that because I will get in trouble if I talk about it." The note indicated R1, "isolated himself in his room."</p> <p>- February 19, 2024, documented by RN-A, indicated she spoke to R1 regarding the residents complaints about food and comparing his prior living arrangements with the current the facility. The note indicated R1 continued to "blame and compare," the facility food to prior facility. RN-A told the resident, "if he is not happy here it is best [R1] should look and start moving out. No reason to compare and criticize."</p> <p>- April 30, 2024, documented by ULP-F, indicated R1 has "bipolar behavior", and ULP-F does not "want to care for a person who jeopardizes not only my job but also puts my license at risk with false statements and accusations of abuses." "I cannot express the amount of stress I have to deal with" R1. The note indicated ULP-F felt "betrayed" by R1, and sometimes the resident treated staff,"like we're some animal or servants." The progress note indicated, "I ' m saying, as a caregiver, if my cares doesn't [sic] meet his needs and expectations, he can go find elsewhere who can meet him with his standards and expectations he sets. I'm not kissing ass."</p>	02380			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39234	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/30/2024
NAME OF PROVIDER OR SUPPLIER DIVERSITY HOME CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3853 KINGS WOOD COURT EAGAN, MN 55122		
(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
02380	<p>Continued From page 11</p> <p>R1's diagnosis list dated November 17, 2022, does not include a diagnosis of bipolar disorder or delusional disorder.</p> <p>R1's progress notes dated January 3, 2024, through April 30, 2024, indicated R1 "isolated" in his room a total of 70 times.</p> <p>During interview on April 30, 2024, at 11:00 a.m., R1 stated the facility had rules which determined his bedtime and daily activities. R1 stated facility staff accuse him of being selfish when he requests how he wants his cares completed. R1 stated when he has a visitor, the visitor is told they have to leave at 6:00 p.m. because visiting hours are over. The resident stated he is fearful to give his opinion, and just tries to keep to himself and stay in his room.</p> <p>During interview on April 30, 2024, at 12:15 p.m., RN-A, stated R1 came to the facility because she knew R1 from another facility and they got along well. When R1 arrived, things went well for the first few months, however, the resident started to complain about staff and had, "high expectations." RN-A stated she told R1 the staff were not his "servants", and if he did not agree with the rules he could find elsewhere to live.</p> <p>R2 R2 was admitted to the facility on June 27, 2023. R2's diagnoses included functional quadriplegia (paralysis of all four limbs), dysphasia (difficulty swallowing), aphasia (loss of ability to express or understand speech), and major depressive disorder.</p> <p>R2's assessment dated April 16, 2024, indicated R2 received services to include: assistance with</p>	02380			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39234	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/30/2024
NAME OF PROVIDER OR SUPPLIER DIVERSITY HOME CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3853 KINGS WOOD COURT EAGAN, MN 55122		
(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
02380	<p>Continued From page 12</p> <p>medication management and administration, bathing, dressing, grooming, ambulation, transfers with assist of two staff with the use of a Hoyer (mechanical device utilizing a body sling), incontinence cares and hydration assistance. Additionally, R2 had difficulty communicating, finishing thoughts and communicated with staff through an electronic device. R2 had a history of depression, anxiety and was total care dependent on staff for all activities of daily living (ADL's).</p> <p>R2's progress notes dated January 20, 2024 through April 28, 2024, indicated the following:</p> <p>- January 20, 2024, documented by ULP-B, indicated R2 said he did not want to take a shower. RN-A came and talked to R2 and helped transfer R2 into the shower chair. R2 kicked at the staff, and RN-A called Admin-D to come and talk to the resident and, "push [R2] to shower." The note indicated ULP-B tried to put water on the resident but R2, "was not being cooperative." R2 was, "Misbehaving after the shower," and RN-A stated if the resident did not want to cooperate then R2, "will have to stay in [R2] room." The note indicated R2 was given, "some space."</p> <p>- February 3, 2024, documented by ULP-B, indicated R2 spit water out when brushing his teeth and got ULP-B's shirt wet. ULP-B told R2 if he "misbehave," then ULP-B, "will not provide cares," for the resident.</p> <p>- March 12, 2024, documented by ULP-F, indicated R2 was "uncooperative" with cares. ULP-F indicated she told the resident if he continued to "mistreat" ULP-F, she would not take care of the resident, "due to bad behavior. Unacceptable."</p>	02380			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39234	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/30/2024
NAME OF PROVIDER OR SUPPLIER DIVERSITY HOME CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3853 KINGS WOOD COURT EAGAN, MN 55122			
(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
02380	<p>Continued From page 13</p> <p>- March 29, 2024, documented by ULP-B, indicated R2 was agitated and told staff he didn't want to eat at that time. R2 was pushing away ULP-B's arms when she was trying to put R2's "bib" on. The note indicated another staff tried to redirect R2 and was able to put the "bib" on the resident but R2 wanted to watch a movie before he ate.</p> <p>- April 2, 2024, documented by ULP-C, indicated R2 was not out in the common area with the other residents because R2 was, "Misbehaving so the nurse said to keep resident in his room." ULP-C indicated she talked with R2 about his "behavior," but the resident did "not recall" his behavior.</p> <p>- April 12, 2024, documented by RN-A indicated R2 had poor insight into his mental health and, "Staff express their misery" providing cares to the resident and R2 is "noncompliance with instruction," when staff explain to the resident he can not be aggressive towards staff.</p> <p>- April 12, 2024, documented by ULP-F, indicated R2 was being "uncooperative and aggressive." The note indicated ULP-F was "exhausted of providing cares," for R2.</p> <p>During interview on May 1, 2024, at 9:46 a.m. R2's family member, (FAM)-H stated R2 had been hospitalized with COVID-19 and a stroke prior to moving to the facility. Since R2 had been living at the facility, FAM-H stated facility management has been pressuring family to approve increased sedative medications for R2's "delirium." FAM-H stated RN-A and Admin-D had both told family if R2 does not increase "behavior" medication for R2 they will discharge R2 from the facility. FAM-H stated they had not seen any</p>	02380			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39234	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/30/2024
NAME OF PROVIDER OR SUPPLIER DIVERSITY HOME CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3853 KINGS WOOD COURT EAGAN, MN 55122		
(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
02380	<p>Continued From page 14</p> <p>change in behavior from R2 and the residents physican felt no medication changes were necessary.</p> <p>R3 R3 was admitted to the facility on April 18, 2023. R3's diagnoses included quadriparesis (condition characterized by weakness in all four limbs, both arms and both legs), seizure disorder and bladder neurogenesis (lack of bladder control due to a brain, spinal cord, or nerve problem).</p> <p>R3's assessment dated April 28, 2024, indicated R3 required assistance of two staff for all activities of daily living (ADL's) to include: medication administration, dressing, undressing, grooming, hygiene, bathing/showering, incontinence care, repositioning, transfers with a Hoyer lift (a mechanical device utilizing a sling), wound care, ambulation, compression stockings on and off (TEDs), meals, housekeeping and laundry. Additionally, R3's assessment indicated R3 experienced episodes of anxiety, was forgetful, required redirection and was dependent on staff for all ADL's.</p> <p>R3's progress notes dated January 11, 2024, through April 30, 2024, included the following:</p> <p>- January 11, 2024, documented by ULP-B indicated R3 requested she be catheterized (cath) (a process to drain urine from the bladder). R3's request was denied and R3 was told by ULP-B she was "allowed to cath twice a day on each shift".</p> <p>- January 16, 2024, documented by ULP-B indicated R3 requested to get up at 10:32 a.m. R3 was denied due to ULP-B feeding three other residents. R3 questioned ULP-B and was told</p>	02380			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39234	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/30/2024
NAME OF PROVIDER OR SUPPLIER DIVERSITY HOME CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3853 KINGS WOOD COURT EAGAN, MN 55122		
(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
02380	<p>Continued From page 15</p> <p>she took longer than others to get up. ULP-B wrote R3 was upset and gave ULP-B "attitude".</p> <p>- January 19, 2024, documented by ULP-B indicated R3 requested assistance with soap and water peri-cares five times prior to 9:00 a.m., due to R3 stating she smelled of urine. R3 was denied assistance each time until a brief change was completed prior to R3 leaving the facility for a late morning appointment. R3 requested to be catheterized prior to leaving facility for the appointment, R3's request was denied until R3 returned from appointment at 2:30 p.m.</p> <p>- January 20, 2024, documented by ULP-B indicated R3 requested peri-care and to get up for the day "around 9:40 a.m." R3 was denied the request and was told staff were busy with other residents and prepping lunch. ULP-B wrote she requested the nurse to "have a talk" with the resident. RN-A told R3 mornings were busy and "it would be best if [R3] get up after lunch".</p> <p>- January 29, 2024, documented by ULP-B indicated R3 requested her vape pen (electronic device used to inhale vapors). R3's request was denied, and ULP-B told R3 the nurse instructed R3 "needs to finish trying to have a bowel movement before her pen". Additionally, ULP-B wrote R3 was upset by the directive and requested to speak with the nurse. ULP-B wrote R3's call pendant alert was disregarded when activated because ULP-B "was just in the room".</p> <p>- January 29, 2024, documented by ULP-F indicated R3 was "very agitated" and requested staff assist the resident with personal cares in a manner the resident preferred. R3's request was denied, and ULP-F wrote she redirected the resident "not demand for staff to do cares her</p>	02380			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39234	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/30/2024
NAME OF PROVIDER OR SUPPLIER DIVERSITY HOME CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3853 KINGS WOOD COURT EAGAN, MN 55122		
(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
02380	<p>Continued From page 16</p> <p>way". Additionally, ULP-F wrote, the manager spoke with the resident,</p> <p>- February 6, 2024, documented by ULP-E indicated R3 "keeps ringing call light, told them to stop many times so staff unplug call light".</p> <p>- February 6, 2024, documented by ULP-F indicated R3 reported staff were causing pain and discomfort while completing personal cares. R3 requested the cares be completed in her preferred manner. R3's request was denied, and ULP-F told R3 staff were trained to complete cares the way the nurse directed.</p> <p>- February 7, 2024, documented by ULP-B indicated R3 requested "to get up at 9 am everyday". R3's request was denied, and RN-A told R3 "it's not possible" for staff to assist R3 at 9:00 a.m. everyday due to other residents to care for and "it's not good" for the resident to be in her wheelchair for long hours.</p> <p>- February 19, 2024, documented by ULP-B indicated R3 requested to remain out of bed following a wheelchair demonstration. R3's request was denied, and ULP-B wrote, R3 "did not want to go back to bed after the demo but redirect that it's her shower day and she have to go back to bed and it's RN instructions to follow." On shower days R3 was required to remain in bed until late afternoon when her shower was scheduled.</p> <p>- February 20, 2024, documented by ULP-F indicated, R3 requested to get up in her wheelchair "earlier than the normal time hours staffs are trained to get her up". Additionally, R3 requested to be cathed and have personal cares completed in her preferred manner. R3's</p>	02380			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39234	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/30/2024
NAME OF PROVIDER OR SUPPLIER DIVERSITY HOME CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3853 KINGS WOOD COURT EAGAN, MN 55122		
(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
02380	<p>Continued From page 17</p> <p>requests were denied, and ULP-F wrote she had notified the RN.</p> <p>- February 23, 2024, documented by ULP-F indicated R3 had exceeded the parameters set by the nurse for use of her call pendant alert. ULP-F wrote R3 requested to be cathed, have her personal cares completed according to her preferred methods and for staff to get her up "earlier than normal time staff trained to get her up". R3 shared concerns about the night shift. R3's requests were denied. Additionally, ULP-F wrote the nurse was notified and R3 "argued that she sat on her bowel movement during the time RN was redirecting" her.</p> <p>- February 27, 2024, documented by RN-A indicated R3 reported feeling constipated all day and requested an enema. RN-A directed R3 to report such symptoms to the morning shift and not the evening shift. R3 stated "I don't want to stay in bed all day". R3 was upset with RN-A's directive.</p> <p>- March 2, 2024, documented by ULP-B indicated R3 requested ULP-B remove the straight cath tube as it was causing pain when ULP-B pushed fluid into the cath tube. R3's request was denied, and ULP-B stated to R3, " we was not blasting water in".</p> <p>- March 20, 2024, documented by ULP-B indicated R3 requested to get up earlier than scheduled. ULP-B wrote "today is another resident enema day and there's only one staff on shift today so [R3] have to be patient and wait after lunch, [R3] was upset". R3's request was denied. Additionally, ULP-B wrote, "on days were not too busy we can get her up but if it's the day we're busy then we can't". R3 requested to</p>	02380			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39234	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/30/2024
NAME OF PROVIDER OR SUPPLIER DIVERSITY HOME CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3853 KINGS WOOD COURT EAGAN, MN 55122		
(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
02380	<p>Continued From page 18</p> <p>Speak with RN-A.</p> <p>- March 26, 2024, documented by ULP-F indicated R3 was told by ULP-F she would have to be put into bed to be changed if she had a bowel movement and because ULP-F was the only caregiver R3 would have to remain in bed after the brief change. R3 requested to get back up after the brief change, however, R3's request was denied and R3 remained in bed.</p> <p>- April 25, 2024, documented by ULP-F indicated ULP-F had entered R3's room and began assisting R3 with feeding and medication administration. R3 requested personal cares and a transfer to her wheelchair be completed while ULP-F was in R3's room. R3's request was denied, and ULP-F told R3 other resident cares were scheduled to be done and R3 would have to wait. R3 was upset by ULP-F's response and requested ULP-F leave her room. ULP-F wrote R3 became "Very Dismissive behavior. Argumentative. Combative. Uncooperative. Mocking." A verbally aggressive conversation had begun between ULP-F and R3. ULP-F wrote, "I am not going to deal with your bullshit. I am going to attend the boys now." ULP-F wrote RN-A was notified about R3's behavior and "I literally wipe her ass everyday, feed, transfer, range, peri care, cath, administer meds, socialize as needed, brief change, help [R3] brush her teeth, prep three meals a day for not only [R3] alone but three other residents, too. I cannot and do not want to work with [R3] due to repeated behavior history and the false accusations and gossip about staffs including writer itself. I am done with my two honeybuns".</p> <p>April 28, 2024, documented by ULP-B indicated R3 requested to use her heating pad three times.</p>	02380			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39234	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/30/2024
NAME OF PROVIDER OR SUPPLIER DIVERSITY HOME CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3853 KINGS WOOD COURT EAGAN, MN 55122		
(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
02380	<p>Continued From page 19</p> <p>R3's request was denied, and ULP-B wrote R3 was told to talk to the nurse because staff were following the nurse's directive.</p> <p>During an interview on May 15, 2024, at 10:35 a.m., R3 stated, "If I don't get up early enough, I have to wait until after lunch."</p> <p>During an interview on May 16, 2024, at 8:39 a.m., unlicensed personnel (ULP)-B stated there were times R3 would request to get up earlier than her scheduled time. ULP-B stated she was unable to assist R3 in getting up because she was the only staff member available at the time and had to provide other tasks for other residents. Additionally, ULP-B stated residents utilizing a Hoyer lift would have to wait until two staff were available to assist.</p> <p>R4 R4 was admitted to the facility on January 10, 2023. R4's diagnoses included included right-sided stroke, aphasia (difficulty swallowing), and traumatic brain injury.</p> <p>R4's assessment dated February 8, 2024, indicated R4 was non-verbal and required assistance of two staff for all ADL's to include: gastrostomy-tube medication administration (crushed medications mixed with solution and provided through a tube into the stomach requiring a water flush prior to and following administration), nebulizer treatments, dressing, undressing, grooming, hygiene, bathing/showering, incontinence care, catheter care, repositioning, transfers with a mechanical sling lift, ambulation, housekeeping and laundry. Additionally, R4's assessment indicated R4 had difficulty communicating some words and/or finishing thoughts, was non-verbal, experienced</p>	02380			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39234	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/30/2024
NAME OF PROVIDER OR SUPPLIER DIVERSITY HOME CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3853 KINGS WOOD COURT EAGAN, MN 55122		
(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
02380	<p>Continued From page 20</p> <p>periods of anxiety, irritability, frustration and would become agitated when he was unable to go outside. R4 required total care and was dependent on staff for all ADL's.</p> <p>R4's progress notes dated January 7, 2024, through April 20, 2024, indicated the following:</p> <ul style="list-style-type: none">- January 7, 2024, documented by ULP-C indicated R4 was "anxious", "inpatient" and requested to go to bed. R4's request was denied, and ULP-C wrote "I will be assisting him to bed after helping other resident first."- January 27, 2024, documented by ULP-F indicated R4's family arrived for a visit at 5:55 p.m., "5 minutes before closing hours" and left at 6:20 p.m., "past closing hours".- February 4, 2024, documented by a ULP indicated R4 had been transferred to bed "by 5:00 p.m." and a visitor arrived at the facility at 5:10 p.m. to see R4. The visitor questioned why R4 was in bed so early and the ULP stated to the visitor R4 "was up since noon and [R4] cannot be sitting for a very long period of time". The visitor left at 6:00 p.m.- February 10, 2024, documented by ULP-C indicated R4 had a visitor at 5:00 p.m. Staff were busy with other residents and the visitor offered to push R4 back to his room. ULP-C told the visitor only staff were allowed to assist residents. The visitor proceeded to assist R4 back to his room while ULP-C was with another resident. ULP-C stopped with the other resident and went to R4's room to transfer R4 into bed with a mechanical sling lift (mechanical lifting/transferring device utilizing a body sling). The visitor and ULP-C exchanged verbal disagreements about R4 being	02380			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39234	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 04/30/2024
NAME OF PROVIDER OR SUPPLIER DIVERSITY HOME CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3853 KINGS WOOD COURT EAGAN, MN 55122		
(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
02380	<p>Continued From page 21</p> <p>placed in bed early. ULP-C wrote the visitor was reminded visiting hours were over at 6:00 p.m. and ULP-C requested the visitor sign out.</p> <p>- February 17, 2024, documented by ULP-B indicated R4 was upset because "he can't get what he wants". R4 observed RN-A remove his loveseat from his room without consulting with him first. ULP-B wrote R4 was upset by this.</p> <p>- March 16, 2024, documented by ULP-H indicated R4 had a visitor arrive at 5:45 p.m. and had brought R4 some sweet treats, protein drinks and clothing. At 6:00 p.m. ULP-H told the visitor visiting hours were over and the visitor left.</p> <p>- March 17, 2024, documented by ULP-H indicated R4 had a visitor arrive at 5:45 p.m. and had brought R4 some items. At 6:00 p.m. ULP-H told the visitor visiting hours were over and the visitor left.</p> <p>- March 29, 2024, documented by ULP-B indicated R4 requested to wear his shoes. ULP-B denied R4's request and told R4 "he only need to wear it when he go to the hospital."</p> <p>- April 3, 2024, documented by ULP-B indicated R4 had gotten upset when staff questioned him about his G-tube tape and did not want to eat. R4 attempted to move ULP-B's hands away from feeding him. ULP-B wrote R4 was told if he did not eat now, he would be "hungry times two" because dinner would not be until later.</p> <p>- April 13, 2024, documented by ULP-B indicated R4 had a visitor at 6:00 p.m. ULP-B wrote the visitor was told to leave and the visitor disagreed with the time stating it was 5:50 p.m. The visitor fed R4 ice cream and ULP-B directed the visitor</p>	02380			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39234	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/30/2024
NAME OF PROVIDER OR SUPPLIER DIVERSITY HOME CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3853 KINGS WOOD COURT EAGAN, MN 55122		
(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
02380	<p>Continued From page 22</p> <p>to stop feeding R4 ice cream because "it was too many sweets for him". ULP-B wrote she directed the visitor to leave "a couple times and it took a while for the visitor to leave.</p> <p>- April 14, 2024, documented by ULP-B indicated R4 was upset because RN-A had directed staff that R4 was not allowed to go outside.</p> <p>- April 14, 2024, documented by ULP-H indicated R4 was "agitated and angry" due to not being allowed outside. ULP-H wrote R4 was "forbid to go outside to prevent any illness."</p> <p>- April 14, 2024, documented by RN-A indicated staff had reported to RN-A that R4's visitor had fed R4 an entire carton of ice cream. RN-A had directed visitors to "give all foods and snacks to staff." RN-A wrote R4's visitor was "uncooperative, agitated and is noncompliance with instructions and house rules".</p> <p>- April 16, 2024, documented by ULP-C indicated staff were told R4's visitor was not allowed to visit until further notice.</p> <p>- April 18, 2024, documented by Administrator (Admin-D) indicated R4 had a visit by his legal representative and R4 had been informed he had visitors that would no longer be allowed to visit. Admin-D wrote "we let [R4] know that if he does not like the decision that he can make the decision to go to the hospital or find a new home if he would like. He seemed to understand this and became less vocal after he was told this information".</p> <p>- April 20, 2024, documented by ULP-C indicated R4 was "very agitated" and pushed himself towards the kitchen. ULP-C wrote she apologized</p>	02380			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39234	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/30/2024
NAME OF PROVIDER OR SUPPLIER DIVERSITY HOME CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3853 KINGS WOOD COURT EAGAN, MN 55122		
(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
02380	<p>Continued From page 23</p> <p>to R4 about his visitor situation and transferred R4 to bed.</p> <p>During an interview on May 16, 2024, at 8:39 a.m., ULP-B stated residents were allowed visitors during business hours, between the hours of 10:00 a.m. and 6:00 p.m. and a visitors sign with hours was previously posted. ULP-B stated if residents wanted to go outside staff would determine if the weather was appropriate, if staff determined the weather was not warm enough the residents were not taken outside, regardless of residents desire to go outside.</p> <p>During an interview on May 21, 2024, at 9:30 a.m., RN-A stated R4 wasn't always able to go outside when he wanted because the weather needed to be above 50 degrees Fahrenheit (F). Additionally, RN-A stated staff did not always have time to sit outside with R4.</p> <p>The facility's Resident Handbook (undated) indicated "We will empower residents to live as they wish by offering choices, always involving family and friends." Additionally, the Resident Handbook contained a Section I., Vulnerable Adult Act: Protection of Assisted Living residents is a right provided for by the State of Minnesota and supported by [facility name]. The Vulnerable Adult Act provides that no employee, visitor, or family member may be involved in any act or abuse or neglect. Any incident observed should be reported to the Housing Director or Director of Nursing. All such incidents will be investigated and reported to the proper authorities.</p> <p>TIME PERIOD FOR CORRECTION: Two (2) days.</p>	02380			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39234	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/30/2024
NAME OF PROVIDER OR SUPPLIER DIVERSITY HOME CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3853 KINGS WOOD COURT EAGAN, MN 55122			
(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
02400	Continued From page 24	02400			
02400 SS=F	<p>144G.91 Subd. 12 Visitors and social participation</p> <p>(a) Residents have the right to meet with or receive visits at any time by the resident's family, guardian, conservator, health care agent, attorney, advocate, or religious or social work counselor, or any person of the resident's choosing. This right may be restricted in certain circumstances if necessary for the resident's health and safety and if documented in the resident's service plan.</p> <p>(b) Residents have the right to engage in community life and in activities of their choice. This includes the right to participate in commercial, religious, social, community, and political activities without interference and at their discretion if the activities do not infringe on the rights of other residents.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to respect the resident's right to have visitors at any time. This had the potential to affect all residents (R1 R2, R3, and R4) residing at the facility.</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) and was 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).</p> <p>The findings include:</p> <p>An undated resident handbook provided by the</p>	02400			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39234	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/30/2024
NAME OF PROVIDER OR SUPPLIER DIVERSITY HOME CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3853 KINGS WOOD COURT EAGAN, MN 55122		
(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
02400	<p>Continued From page 25</p> <p>licensee to all residents (R1, R2, R3, and R4) included a policy titled U:Guests, and indicated, "The action and conduct of all guests are the responsibility of the resident. Please supervise and accompany your guests within the residence at all times. Also, be respectful that this is also your housemates' home and people have different schedules. With this in mind, if you are expecting guests at any other times outside of 10:00 a.m. to 6:00 p.m., please speak with [facility name's] director of nursing (DON) or Business Manager for approval. [Facility name] reserves the right to ban any and all guests who come to [facility name] with intent to do harm or disturb staff or other residents at the facility or damage [facility name] property. We ask that you inform your visitor to sign in at the front desk and wear a "visitor" badge at all times while in residence".</p> <p>R1 was admitted to the facility on November 11, 2022. His diagnoses include juvenile rheumatoid arthritis. R1 receives assistance with medications, toileting, bathing, dressing, grooming, meals, transfers, housekeeping, and laundry.</p> <p>During an interview on April 30, 2024 at 10:40 a.m., R1 stated the facility amended visitation hours to be between 10:00 a.m. to 6:00 p.m. R1 expressed displeasure with the visiting hours and stated the facility had a lot of rules and restrictions.</p> <p>The facility lacked an Individual Abuse Prevention Plan (IAPP) to address R1's visitor restrictions.</p> <p>R2 was admitted to the facility on June 27, 2023. R2's diagnoses include functional quadriplegia, dysphasia, aphasia, and major depressive disorder. R2 receives assistance with transfers,</p>	02400			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39234	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/30/2024
NAME OF PROVIDER OR SUPPLIER DIVERSITY HOME CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3853 KINGS WOOD COURT EAGAN, MN 55122		
(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
02400	<p>Continued From page 26</p> <p>toileting, bathing, dressing, grooming, eating, medications, and ambulation.</p> <p>The facility lacked an Individual Abuse Prevention Plan (IAPP) to address R2's visitor restrictions.</p> <p>R3's diagnoses included quadriparesis (condition characterized by weakness in all four limbs both arms and both legs), seizure disorder and bladder neurogenesis (lack of bladder control due to a brain, spinal cord, or nerve problem).</p> <p>R3's assessment dated April 28, 2024, indicated R3 required assistance of two staff for all activities of daily living (ADL's) to include: medication administration, undressing, grooming, hygiene, bathing/showering, incontinence care, repositioning, transfers with a mechanical device utilizing a sling, wound care, ambulation, compression stockings on and off (TEDs), meals, housekeeping and laundry. Additionally, R3's assessment indicated R3's children resided in the area.</p> <p>The facility lacked an Individual Abuse Prevention Plan (IAPP) to address R3's visitor restrictions.</p> <p>R4's diagnoses included quadriplegic, traumatic brain injury (TBI) and aphasia (reading, speaking, writing disorder).</p> <p>R4's assessment dated February 8, 2024, indicated R4 was non-verbal and required assistance of two staff for all activities of daily living to include: gastrostomy-tube medication administration (crushed medications mixed with solution and provided through a tube into the stomach requiring a water flush prior to and following administration), nebulizer treatments, dressing, undressing, grooming, hygiene,</p>	02400			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39234	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/30/2024
NAME OF PROVIDER OR SUPPLIER DIVERSITY HOME CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3853 KINGS WOOD COURT EAGAN, MN 55122		
(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
02400	<p>Continued From page 27</p> <p>bathing/showering, incontinence care, catheter care, repositioning, transfers with a sling mechanical lift, ambulation, housekeeping and laundry. Additionally, R4's assessment indicated R4's support network was very limited.</p> <p>A progress note dated February 10, 2024, included the following: "Staff reminds [R4's family] that visiting time is over at 1800 (6:00 p.m.) and will need her to sign in and out at that time."</p> <p>A progress note dated March 16, 2024, included the following: R4 "had a visitor, [R4's family] at 5:45 p.m.. [R4's family] brings in ice cream, ensures (nutritional supplements), and more clothing. at 6:00 p.m., told the [R4's family] that visiting time is over. Visitor left."</p> <p>A progress note dated March 17, 2024, included the following: R4 "had a visitor, [R4's family] at 5:45 p.m.. [R4's family] brings in ice cream, ensures, and more clothing. at 6:00 p.m., told the [R4's family] that visiting time is over. Visitor left."</p> <p>A progress note dated April 13, 2024, included the following: " [R4's family] visit at 6 p.m. and had to tell [R4's family] to leave because visiting hours are over, [R4 family] stated that it's only 5:50 p.m. and she still have 10 min left to visit client. It's past 6 p.m. and have to tell visitor to leave a couple times and it take awhile for visitor to leave."</p> <p>A progress note dated April 14, 2024, included the following: R4's family was "noncompliance [sic] with instructions and house rules. [R4's family] is argumentative and she (family member) will not stop. She does what she want [sic]whenever she visit [R4]. Explain that she will follow the house rules and do not transfer [R4's name] to bed</p>	02400			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39234	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/30/2024
NAME OF PROVIDER OR SUPPLIER DIVERSITY HOME CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3853 KINGS WOOD COURT EAGAN, MN 55122			
(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
02400	<p>Continued From page 28</p> <p>when she visit. Asked [R4's family] to leave due to her poor insight and her out of control behavior. She (R4's family member) threatening to call the police."</p> <p>A progress note dated April 16, 2024, included the following: "Staff was told client's [R4's family] is not allowed to visit until further notices."</p> <p>A progress note dated April 18, 2024, included the following: " [guardian name] came to visit [R4's name] this morning to inform him that his [R4's family] is no longer allowed to visit our facility for some time. She had mentioned a 6 month period that [R4's family] would not be allowed to visit or maybe come up with a different way for her to visit [R4's name] in the future. [R4's name] seemed to be upset a bit and that was to be expected since [R4's family] often comes and feeds [R4's name] foods that we do not agree with her feeding him. Usually it is a sweet treat and is usually more than we would ever feed him in one setting. We have asked for [guardian name] help and she now has banned [R4's family] for now, from our facility. Staff has been notified to not let her in and if she does not leave, to call the police. We let [R4's name] know that if he does not like the decision that he can make the decision to go to the hospital or find a new home if he would like. He seemed to understand this and became less vocal after he was told this information."</p> <p>A progress note dated April 20, 2024, at 2:20 p.m. indicated staff were notified that R4's family and her boyfriend stop by to visit when they were not allowed to visit according to a court order. R4's family was augmentative with staff when the family was told to leave. R4's family stated they spoke with R4's guardian and can continue to</p>	02400			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39234	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/30/2024
NAME OF PROVIDER OR SUPPLIER DIVERSITY HOME CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3853 KINGS WOOD COURT EAGAN, MN 55122		
(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
02400	<p>Continued From page 29</p> <p>visit as the family chooses. The licensee asked R4's family to leave the facility but they continued to refuse. Explained to R4's family, if the family do not obey the rules by the court the staff were directed to call the police.</p> <p>A progress note dated April 20, 2024, written by an unlicensed personnel (ULP) included the following: R4 was "very agitated and pushed himself towards the kitchen." Staff redirected and R4 yelled at staff. Staff apologized to R4 about his family's situation and transferred R4 into bed.</p> <p>On April 16, 2024, a visitor restriction letter was given to R4 and copies sent to R4's family members. The restriction letter indicated the following restrictions on R4 and R4's family:</p> <ul style="list-style-type: none">- Visits will be limited to 3 x/week.- Visiting hours are 10:00 a.m. to 6:00 p.m.- During these visits it is encouraged to spend quality time with family members and not with caretakers.- Please be respectful of caretaker's duties during this time as they are trained in your family members' cares.- Only staff can transfer [R4]. Family is not to do any transferring at any time.- If there is a concern that you are under the influence of anything that might affect your judgement, you will be asked to leave the home. If you refuse, police will be called.- If the visit turns tumultuous or disruptive to the home in any way, the staff will ask you to leave. If you refuse, police will be called.- Calls only during visiting hours.- Caretakers will not be answering text messages.- Caretakers will be taking 1 call/day for family member.- Caretakers will be returning 1 call a week for	02400			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39234	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/30/2024
NAME OF PROVIDER OR SUPPLIER DIVERSITY HOME CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3853 KINGS WOOD COURT EAGAN, MN 55122		
(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
02400	<p>Continued From page 30</p> <p>updates on family members.</p> <p>On May 16, 2024, at 8:39 a.m., unlicensed personnel (ULP)-B stated R4's family was allowed to visit during business hours of 10:00 a.m. to 6:00 p.m. and a visiting hours sign was posted at one time.</p> <p>On May 20, 2024, at 10:30 a.m., R4's guardian (G)-G stated a member of R4's family had not followed guidelines put in place by licensee and caused disruption at the facility, as reported by facility to G-G. G-G stated her knowledge of the family disruptions had come from either the facility or a previous guardian and G-G had been a guardian for R4 since December 2023. G-G had never met with the family or asked for assistance from an Ombudsman on behalf of R4. G-G stated she had one conversation with R4's family member and it was not a productive conversation as the family member accused the facility of emotional abuse and "was irate". G-G did not feel the family member was stable or safe to be around R4 or the facility. G-G stated she was unaware of how R4 felt about not being allowed to have visits from his family member and G-G stated, "that's difficult as he is non-verbal". G-G stated it had been an on-going issue prior to her involvement with R4.</p> <p>A District Court Affidavit of Service document indicated on April 16, 2024, indicated four members of R4's family were served the same visitation restrictions by United States mail service.</p> <p>The facility lacked an Individual Abuse Prevention Plan (APP) to address R4's visitor restrictions.</p> <p>The facility lacked a signed service plan for R4 to</p>	02400			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39234	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/30/2024
NAME OF PROVIDER OR SUPPLIER DIVERSITY HOME CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3853 KINGS WOOD COURT EAGAN, MN 55122			
(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
02400	<p>Continued From page 31</p> <p>address restrictions placed on R4.</p> <p>On April 30, 2024, at 10:00 a.m., registered nurse (RN)-A stated facility visiting hours are 10:00 a.m. to 6:00 p.m. RN-A stated the staff are busy and they cant have visitors, "snooping," all over the facility.</p> <p>The Minnesota Bill of Rights for Assisted Living Residents, last updated November 8, 2022, indicated residents have the right to individual autonomy, initiative, and independence in making life choices, including establishing a daily schedule and choosing with whom to interact. In addition, the resident has the right to meet with or receive visits at any time from the resident's family, guardian, conservator, health care agent, attorney, advocate, religious or social work counselor, or any person of the resident's choosing. This right may be restricted in certain circumstances if necessary for the resident's health and safety and if documented in the resident's service plan.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days.</p>	02400			
02560 SS=F	<p>144G.92 Subdivision 1. Retaliation prohibited</p> <p>A facility or agent of a facility may not retaliate against a resident or employee if the resident, employee, or any person acting on behalf of the resident:</p> <p>(1) files a good faith complaint or grievance, makes a good faith inquiry, or asserts any right;</p> <p>(2) indicates a good faith intention to file a complaint or grievance, make an inquiry, or</p>	02560			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39234	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/30/2024
NAME OF PROVIDER OR SUPPLIER DIVERSITY HOME CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3853 KINGS WOOD COURT EAGAN, MN 55122		
(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
02560	<p>Continued From page 32</p> <p>assert any right; (3) files, in good faith, or indicates an intention to file a maltreatment report, whether mandatory or voluntary, under section 626.557; (4) seeks assistance from or reports a reasonable suspicion of a crime or systemic problems or concerns to the director or manager of the facility, the Office of Ombudsman for Long-Term Care, the Office of Ombudsman for Mental Health and Developmental Disabilities, a regulatory or other government agency, or a legal or advocacy organization; (5) advocates or seeks advocacy assistance for necessary or improved care or services or enforcement of rights under this section or other law; (6) takes or indicates an intention to take civil action; (7) participates or indicates an intention to participate in any investigation or administrative or judicial proceeding; (8) contracts or indicates an intention to contract to receive services from a service provider of the resident's choice other than the facility; or (9) places or indicates an intention to place a camera or electronic monitoring device in the resident's private space as provided under section 144.6502.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure four of four residents (R1, R2, R3, R4), were not retaliated against. The licensee failed to provide an environment where residents have the ability to file a good faith complaint, grievance, or maltreatment report without fear of losing their housing.</p> <p>This practice resulted in a level two violation (a</p>	02560			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39234	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/30/2024
NAME OF PROVIDER OR SUPPLIER DIVERSITY HOME CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3853 KINGS WOOD COURT EAGAN, MN 55122		
(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
02560	<p>Continued From page 33</p> <p>violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was 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).</p> <p>The findings include:</p> <p>Review of R1, R2, R3, and R4's records included a undated memo which was delivered January 2, 2024, from the licensee to every resident which indicated, "Our Policy for nighttime oral and hygiene care is being amended. All oral and hygiene evening care will be conducted by 10:00 p.m. There will be no exceptions. You will be able to go to bed whenever you like but unless your service plan is on you 6790 (county service plan) we will not be providing additional services at the times you demand. Calling out staff sweetie, honey or any other name other than their name is sexist and will not be tolerated. If demands and requests remain and do not go with our policy, you will be asked to leave and be given 2 weeks notice to vacate. Calling the police or state on our facility without proper cause will constitute an immediate 2 week notice to vacate our premises. We appreciate you cooperation."</p> <p>R1 was admitted to the facility on November 11, 2022. R1's diagnoses include juvenile rheumatoid arthritis. R1 received assistance with medication administration, toileting, bathing, dressing, grooming, meals, transfers, housekeeping, and laundry.</p> <p>On December 21, 2023, at 12:15 a.m., administrator (Admin)-D documented in R1's progress notes, "R1 is constantly saying how he</p>	02560			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39234	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/30/2024
NAME OF PROVIDER OR SUPPLIER DIVERSITY HOME CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3853 KINGS WOOD COURT EAGAN, MN 55122		
(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
02560	<p>Continued From page 34</p> <p>can go to bed whenever he wants, which is true. We just told him that we are changing our policy so that all bedtime hygiene with all clients will be done prior to 10:00 p.m. in the evening. He thinks we are saying he has to go to bed/sleep, but that is not what we are saying at all. He can always go to sleep whenever he wants, we are just changing our policy so that all residents will have bedtime hygiene done by 10:00 p.m."</p> <p>Nursing progress note dated April 30, 2024, documented by unlicensed personnel (ULP)-F, included, "He (R1) has a lot of expectations, I'm saying as a caregiver, if my cares doesn't meet his needs and expectations, he can go find elsewhere who can meet him with his standards and expectations he sets. I'm not kissing ass."</p> <p>R2 was admitted to the facility on June 27, 2023. R2's diagnoses include functional quadriplegia (paralysis of both arms and legs), dysphasia (difficulty swallowing), aphasia (difficulty speaking or being understood), and major depressive disorder. R2 received assistance with transfers, toileting, bathing, dressing, grooming, eating, medication administration, and ambulation.</p> <p>R3 R3 was admitted to the facility on April 18, 2023. R3's diagnoses included quadriparesis (weakness in both arms and both legs), seizure disorder and bladder neurogenesis (lack of bladder control due to a brain, spinal cord, or nerve problem).</p> <p>R4 R4 was admitted to the facility on January 10, 2023. R4's diagnoses included right-sided stroke, aphasia and traumatic brain injury.</p> <p>A facility policy titled 2.41 Retaliation Prohibited,</p>	02560			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39234	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/30/2024
NAME OF PROVIDER OR SUPPLIER DIVERSITY HOME CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3853 KINGS WOOD COURT EAGAN, MN 55122		
(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
02560	<p>Continued From page 35</p> <p>dated August 11, 2022, indicated retaliation against a resident included but is not limited to any of the following actions taken or threatened by a facility or an agent of the facility against a resident, or any person with a familial, personal, legal, or professional relationship with the resident: termination of a contract, any form of discrimination, restriction or prohibition of access: (a) of the resident to the facility or visitors, or (b) of a family member or a person with a personal, legal or professional relationship with the resident, to the resident, unless the restriction is the result of a court order, the imposition of involuntary seclusion or the withholding of food, care, or services, restriction of any of the rights granted to residents under state or federal law, restriction or reduction of access to or use of amenities, care, services, privileges, or living arrangement, or , unauthorized removal, tampering with, or deprivation of technology, communication, or electronic monitoring devices.</p> <p>No additional information was provided.</p> <p>TIME PERIOD TO CORRECT: Seven (7) Days.</p>	02560			