



STATE LICENSING COMPLIANCE REPORT

Report #: HL399915080C

Date Concluded: October 4, 2024

Name, Address, and County of Facility

Investigated:

Live Well MN Home Healthcare
8600 Park Avenue South
Bloomington, MN 55420
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Erin Johnson-Crosby, RN
Special Investigator

The Minnesota Department of Health conducted a complaint investigation to determine compliance with state laws and rules governing the provision of care under Minnesota Statutes, Chapter 144G. The purpose of this complaint investigation was to review if facility policies and practices comply with applicable laws and rules. No maltreatment under Minnesota Statutes, Chapter 626 was alleged.

To view a copy of the correction orders, if any, please visit:

<https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html>, or call 651-201-4201 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached state form.

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39991	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/20/2024
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NAME OF PROVIDER OR SUPPLIER LIVE WELL MN HOME HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 8600 PARK AVE SOUTH BLOOMINGTON, MN 55420
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(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>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>HL399915080C</p> <p>On August 20, 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 Provisional Comprehensive Assisted Living license.</p> <p>The following correction order is issued for #HL399915080C, tag identification 1130.</p>	0 000		
01130 SS=G	<p>144G.55 Subd. 2 Safe location</p> <p>A safe location is not a private home where the occupant is unwilling or unable to care for the resident, a homeless shelter, a hotel, or a motel. A facility may not terminate a resident's housing or services if the resident will, as the result of the termination, become homeless, as that term is defined in section 116L.361, subdivision 5, or if an adequate and safe discharge location or adequate and needed service provider has not</p>	01130		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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01130	<p>Continued From page 1</p> <p>been identified. This subdivision does not preclude a resident from declining to move to the location the facility identifies.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of one resident (R1) was discharged to an adequate and safe location and needed service provider. R1 was discharged to a homeless shelter by the licensee on two separate occasions.</p> <p>This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).</p> <p>Findings Include:</p> <p>Minnesota (MN) Statute 144G.55, Subd. 2, Safe Location. A safe location is not a private home where the occupant is unwilling or unable to care for the resident, a homeless shelter, a hotel, or a motel. A facility may not terminate a resident's housing or services if the resident will, as a result of the termination, become homeless, as that term is defined in section 116L.361, Subd. 5, or if an adequate and unsafe discharge location or adequate and needed service provider has not been identified.</p> <p>On an MDH investigator initiated a complaint survey investigation.</p>	01130	<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.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p>	

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01130	<p>Continued From page 2</p> <p>The licensee's provisional assisted living license was effective August 21, 2023, and expired August 20, 2024.</p> <p>R1's medical record was requested but not provided to the investigator.</p> <p>A review of the licensee's discharged or deceased resident roster did not include R1.</p> <p>A report to the Minnesota Adult Abuse Reporting Center (MAARC) dated June 18, 2024, indicated R1 was set to move in to the facility on May 24, 2024, and met the registered nurse (RN)-B at the facility. RN-B reviewed house rules with R1 and R1 moved in. Days later the owner (O)-E informed R1's case manager he was not approved to move to that location and would have to go back to the homeless shelter. R1 was not able to return to the shelter as it was a respite shelter and no beds were available. R1 called the case worker (CW)-C on June 5, 2024, and informed her facility staff picked R1 up the evening of June 4, 2024, and took him back to the homeless shelter because he did not have paperwork completed. The case worker CW-C notified O-E the shelter did not have room for R1 and he would need to go back to the facility. On June 8, 2024, O-E replied that R1 could come back to the facility while his approval was in process but they would need the security deposit and second months rent within two weeks of R1 moving in. On June 10, 2024, R1 was allowed to return to the facility. On June 14, 2024, R1 and O-E informed the CW-C the licensee had not received the required paper worked. Later that day, facility staff dropped R1 off at the respite homeless shelter, however, there were no beds available and R1 was left to find somewhere to stay. Following R1's discharge to the shelter,</p>	01130		

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01130	<p>Continued From page 3</p> <p>CW-C was unable to contact R1.</p> <p>The MDH investigator was provided documentation of email correspondence that occurred between CW-C and licensee staff which included the following:</p> <p>On May 21, 2024, RN-B emailed CW-C indicating R1 could move into the facility and there were two choices.</p> <p>On May 23, 2024, CW-C emailed RN-B indicating R1 wanted to move into the facility and currently R1 was in the hospital but should be discharged in a few days and requested admission for next week. The licensee replied, "Yes, we can do that.</p> <p>On May 29, 2024, CW-C replied to the licensee and indicated a medication list was still needed and R1 could move in Friday at 10:00 a.m. and requested the licensee's address.</p> <p>On May 30, 2024, CW-C emailed the licensee R1's medication list and informed the licensee she would pick up R1 at 10:00 tomorrow. CW-C emailed the licensee requesting that R1 move into the facility later tomorrow around 11:00 a.m., or 11:30 a.m. The licensee replied, "noon is fine."</p> <p>On June 3, 2024, O-E emailed CW-C requesting a phone call. Then CW-C emailed a case manager (CM)-D indicating R1 was not approved at the current facility but for another location and requested if the paperwork would be updated.</p> <p>On June 6, 2024, CW-C emailed the licensee and requested R1 be allowed to return to the facility since the paper work was now completed.</p> <p>On June 14, 2024, CW-C emailed CM-D</p>	01130		

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01130	<p>Continued From page 4</p> <p>indicating the licensee had not received R1's paperwork and R1 would have to go back to the shelter because the state was coming on Monday. Later that day, CW-C emailed the licensee requesting that R1 be allowed to return to the facility since the paperwork was completed. O-A replied, "unfortunately no," a Medica approval letter is needed as it is our official service authorization to admit a client. "We made a one-month free offer and had him move in for a week to get this resolved so I normally don't allow resident to move in without authorization in place." CM-D replied to O-A and indicated an authorization letter from Medica takes more time and usually a couple weeks and did not understand why R1 was moved in if things were not in place. The email indicated the homeless shelter had no space for R1 and R1 was now homeless.</p> <p>On June 17, 2024, O-A emailed CM-D and indicated he was not aware of when R1 moved in to the facility. The licensee took him in because R1 could not afford the other facility and the licensee accommodated R1 out of good will while waiting for a service agreements but clients were not normally admitted without agreed rates and a service agreement in place.</p> <p>During an interview on August 20, 2024, at 1:21 p.m., licensed assisted living director (LALD)/RN-A stated R1 was never admitted since they did not get approval to admit him so they took him back to the homeless shelter. LALD/RN-A stated R1 moved in but was not admitted and no paperwork for R1 was completed.</p> <p>During an interview on August 20, 2024, at 1:30 p.m., O-E stated R1 was never admitted because</p>	01130		

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01130	<p>Continued From page 5</p> <p>the licensee does not admit residents without a security deposit or service agreements. R1 and a county person brought his belonging in while he was gone. O-E stated we can not admit prior authorization and need to get paid to admit the resident. O-E stated if I admit a client, "I can't kick him out." Owner-B stated out of courtesy we let R1 stay two to three nights but the licensee didn't receive approval from insurance so facility staff brought him back to the shelter. O-E stated we did not admit or discharge R1 and stated R1 must have been living somewhere else since R1 had not contacted him again.</p> <p>During an interview on August 22, 2024, at 11:00 a.m., CW-C stated the facility registered nurse (RN) met them at the facility when R1 was admitted. The following Monday she received a call from R1 stating he needed to go back to the shelter because he was not approved to live there. R1 was dropped off at the homeless shelter. Five days later, R1 was allowed to return to the facility. Days later O-E indicated R1 needed to return to the homeless shelter because they had not received the appropriate paperwork and "state" was coming. Facility staff dropped R1 off again at the homeless shelter and there with no beds available. CW-C was not able to contact R1 for around a month after R1 was turned away from the homeless shelter.</p> <p>The licensee's Discharge and Transfer of Residents policy dated August 20, 2023, indicated a safe location was not a private home where the occupant is unwilling or unable to care for the resident, a homeless shelter, a hotel or a motel.</p> <p>No further information was provided.</p> <p>TIME PERIOD TO CORRECT: Seven (7) days.</p>	01130		

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