STATE LICENSING COMPLIANCE REPORT

Report #: HL25371001C

Date Concluded: March 4, 2022

Name, Address, and County of Facility Investigated:
Restart Inc.
4654 Minnehaha Avenue South
Minneapolis, MN 55406
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Rhylee Gilb, RN
Special Investigator
Stephanie Jones de Palma,
Physical Environment
Evaluator

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25371	A. BUILDING: _____ B. WING _____	C 03/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RESTART INC	**4654 MINNEHAHA AVENUE SOUTH MINNEAPOLIS, MN 55406**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL25371001C On March 4, 2022, 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 8 clients receiving services under the provider's Assisted Living license. The following immediate correction order is issued. Correction orders with a period to correct that are not immediate may be issued at a later date during the investigation. The following immediate correction order is issued for #HL25371001C, tag identification 820. On March 4, 2022 at 2:30 p.m., the immediacy was removed, however, non-compliance remains at a scope of G.	0 000	Minnesota Department of Health is documenting the State Licensing 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. 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. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	

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0 000	Continued From page 1 The following correction order is issued that was not issued at the time of immediate correction order, tag identification 470.	0 000		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the licensee failed to develop a staffing	0 470		

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0 470	Continued From page 2 plan that included metrics to identify staffing to meet scheduled and unscheduled needs of residents, including requiring identified awake staff 24hrs a day seven days a week. This affected 8 of 8 residents. 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). The findings include: During an onsite visit on March 4, 2022, at 1:00 p.m., surveyors entered the licensee. In the basement level of the home, there was a conference table in an open area and an enclosed bedroom. The bedroom met legal requirements to be an occupied space. Unlicensed personnel (ULP)-E folded laundry in the room. The room had a twin sized bed, television, tv and other personal belongings. During an interview on March 4, 2022, at 1:08 p.m., ULP-E stated "I'm the sleep staff" when he introduced himself. ULP-E stated he was working late today to help with laundry. ULP-E stated he had worked for the licensee for 17 years. The schedule for sleep staff was 10:00 p.m. to 6:00 a.m. or 7:00 a.m. ULP-E stated he often picks up the weekend overnight shift. The licensee schedule dated January 31, 2022 through March 20, 2022, indicated ULP-E worked everyday during the dates reviewed. ULP-E worked a "live in" shift Monday through Friday	0 470		

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0 470	Continued From page 3 and worked "overnight" on Saturday and Sunday. During an interview on March 4, 2022, at 1:45 p.m., licensed practical nurse (LPN)-C stated ULP-E was a live in staff and the live in staff position was overnight shifts Sunday through Thursday night. LPN-C stated the live in position covers ULP-E's rent and ULP-E often picks up the weekend overnight positions for extra money. Surveyor asked if live in position included sleep staff, as ULP-E introduced himself as the sleep staff. During an interview on March 4, 2022, at 1:47 p.m., licensed assisted living director (LALD)-A answered the inquiry about ULP-E sleeping and stated he should not be and that was news to her if he was sleeping [during the overnight shift.] The surveyor asked what if ULP-E did not pick up the overnight shifts as he was working seven days a week. LALD-A stated they would ask other staff to stay late, pick up the open shifts, or hire for the position. The licensee undated documented titled Staffing Plan, indicated direct care staff would be available 24 hours a day. There was a contingency plan if staff called in, the on-call site manager would work the shift and staff from the previous shift could not leave until the on-call plan as been covered. The staffing plan failed to include the residents needs and metrics for determining staffing requirements to provide scheduled and unscheduled services. TIME PERIOD OF CORRECTION: Seven (7) days	0 470		

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0 820	Continued From page 4	0 820		
0 820 SS=G	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure all facility elements, including, the egress window in the basement resident room, does not create a distinct hazard to residents and staff. This affected one of eight residents (R1) reviewed. R1's dwelling was in basement bedroom #8, with a non-operational egress window. 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). The findings include:	0 820		

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0 820	Continued From page 5 On March 04, 2022, from approximately 1:00 p.m. to 1:45 p.m., survey staff toured the facility with the licensed practical nurse (LPN)-C and director of nursing (DON)-B. During the facility tour, survey staff observed a non-operational egress window in basement bedroom #8. The egress window did not have a ladder and was enclosed by a decorative fence that was tall enough to inhibit the safe egress of R1. DON-B and LPN-C verbally confirmed survey staff observations during the facility tour. During the interview on March 04, 2022, at 2:20 p.m., licensed assisted living director (LALD)-A stated they will get the window to open as soon as possible. At 2:30 p.m., the immediacy was removed, however non-compliance remains at a scope of G. The egress window hazard was discussed with LALD-A, the surveyor, and R1. R1 choose to temporarily relocate to another licensee location with the same owner. The immediate plan of correction (POC) is for R1 to move to Kathy's place. LALD-A stated preliminarily R1 could return on March 7, 2022, given the repair to the egress window and ability to escape from the window well safely. At 2:43 p.m., LALD-A stated they are also trying to contact R1's family member to see if he can stay with her instead of Kathy's Place. May be an alternative. TIME PERIOD FOR CORRECTION: Two (2) days	0 820		