STATE LICENSING COMPLIANCE REPORT

Report #: HL36404001C **Date Concluded:** December 30, 2021

Name, Address, and County of Facility Investigated:
New Hope Health Care, LLC
9220 Bass Lake Road, Suite 395
New Hope, MN 55429
Hennepin County

Facility Type: Assisted Living Facility (ALF) **Evaluator's Name:** Michele R. Larson, RN

Special Investigator

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36404	A. BUILDING: _____ B. WING _____	C 11/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW HOPE HEALTH CARE LLC	**3812 BASS LAKE ROAD NORTH BROOKLYN CENTER, MN 55429**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments Initial comments ******ATTENTION****** HOME CARE PROVIDER/ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144A.43 to 144A.482/144G., the Minnesota Department of Health issued a correction order(s) pursuant to a survey. 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: On November 18, 2021, the Minnesota Department of Health initiated an investigation of complaint #HL36404001C. At the time of the survey, there were three residents receiving services under the assisted living license. The following correction orders are issued for #HL36404001C, tag identification 0740, 1040, 1070, 1130, 1650, 1730, 2350, and 2370.	0 000	Assisted Living Provider 144G. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Home Care Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. 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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0 740	Continued From page 1	0 740		
0 740 SS=E	144G.43 Subd. 4 Transfer of resident records With the resident's knowledge and consent, if a resident is relocated to another facility or to a nursing home, or if care is transferred to another service provider, the facility must timely convey to the new facility, nursing home, or provider: (1) the resident's full name, date of birth, and insurance information; (2) the name, telephone number, and address of the resident's designated representatives and legal representatives, if any; (3) the resident's current documented diagnoses that are relevant to the services being provided; (4) the resident's known allergies that are relevant to the services being provided; (5) the name and telephone number of the resident's physician, if known, and the current physician orders that are relevant to the services being provided; (6) all medication administration records that are relevant to the services being provided; (7) the most recent resident assessment, if relevant to the services being provided; and (8) copies of health care directives, "do not resuscitate" orders, and any guardianship orders or powers of attorney. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure resident records were complete and ready to forward to another service provider for two of two former residents (R1 and R2) with records reviewed. R1 was discharged to an unknown facility. R2 was discharged to a family member. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 740		

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0 740	Continued From page 2 safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). Findings include: On November 18, 2021, at 9:06 a.m., licensed assisted living director (LALD)-A stated there were two residents (R1, R2) who were discharged since the licensee transferred to an assisted living licensure on August 1, 2021. R1 R1's medical record was reviewed. R1 was admitted to the facility on July 19, 2021, under the comprehensive home care license, and began receiving assisted living services on August 1, 2021. R1's diagnoses included paranoid schizophrenia, chronic kidney disease stage 3, chronic systolic heart failure, and hypertension. R1's service plan dated July 19, 2021, indicated R1 received daily assistance with medication management and meals. Review of R1's progress note dated August 5, 2021, indicated at 9:54 p.m., R1 called the facility stating he missed the last bus back to the facility and would return the following morning on August 6, 2021. Review of R1's progress note dated August 6, 2021, LALD-A told R1 he was no longer allowed to live at the facility because he broke curfew. The progress note indicated LALD-A told R1 to "pack his things." R1's social worker (SW)-C was	0 740		

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0 740	Continued From page 3 notified. Review of an email from LALD-A to R1's social worker (SW)-C dated August 6, 2021, at 11:23 a.m., indicated R1 was not allowed back in the facility due to aggressiveness towards facility staff, non-compliance with facility rules, and bringing drugs and alcohol into the facility. The email indicated R1's medications and personal belongings were left at the facility. Review of an undated letter indicated R1 picked up his medications and belongings on August 19, 2021. Review of R1's record indicated no incident reports were completed by staff members regarding R1's aggressiveness towards staff members or staff being fearful of R1. Review of R1's discharge summary dated August 19, 2021, indicated R1 was discharged due to "needs were met." R1's discharge summary indicated R1 was transferred to a different facility. The receiving facility signature was signed by LALD-A. R1's discharge summary lacked the following information: R1's consent and knowledge of his discharge, the name, telephone number, and address of R2's designated representatives, and signature from the receiving facility. On November 18, 2021, at 9:06 a.m., LALD-A stated she was unaware of where R1 moved to after he was discharged from the facility. R2 R2's medical record was reviewed. R2 was admitted to the facility on June 18, 2021, under	0 740		

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0 740	Continued From page 4 the comprehensive home care license and began receiving assisted living services on August 1, 2021. R2's diagnoses included Type 2 diabetes mellitus, and intermittent asthma with acute exacerbation. R2's service plan dated June 18, 2021, indicated R2 received only supportive services. R2's care plan dated August 11, 2021, indicated R2 received assistance with medication management, laundry, and housekeeping, and needed verbal reminders for bathing, showering, and eating. R2 was independent with transfers and mobility. R2 walked independently. R2's progress note dated August 15, 2021, indicated R2 was sent to the hospital for sepsis. There was no documentation if his records were transferred to the hospital. Review of R2's progress note dated August 16, 2021, indicated house manager (HM)-B instructed staff members to not accept calls from R2 when he was hospitalized after R2 called a staff member a "bitch." The progress note indicated HM-B told staff, "He doesn't need anything." Review of R2's progress note dated August 18, 2021, at 5:02 p.m., indicated after R2's hospital discharge, HM-B dropped off R2's belongings and medications at the hospital. Review of R2's undated facility discharge summary indicated R2 was discharged due to "needs met" and discharged to a "family member." R2's discharge summary lacked the following	0 740		

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0 740	Continued From page 5 information: R2's consent and knowledge of his discharge, and the name, telephone number, and address of R2's designated representatives. On November 18, 2021, at 9:05 a.m., LALD-A stated R2 was considered a temporary resident until a long-term care facility was found for him. LALD-A stated R2 was verbally abusive with staff and broke curfew and items in the facility. LALD-A stated, "R2 was physically aggressive and swearing left and right." LALD-A stated the facility "warned" R2 he would be discharged if he did not change his behaviors, stating, "Unfortunately, it didn't work out. He was suicidal, and we could no longer provide cares for him." On December 3, 2021, at 9:55 a.m., house manager (HM)-B stated after R2's discharge from the hospital, a medical transportation vehicle drove him to a family member's home at an unknown location. The licensee policy titled, Discharge of Residents, dated August 1, 2021 indicated if the resident still required services after discharge, the licensee would assist the resident with access to other home care services and would provide the resident or his representative a list of home care providers in the area. TIME PERIOD TO CORRECT: Twenty-one (21) days.	0 740		
01040 SS=E	144G.52 Subd. 7 Notice of contract termination required (a) A facility terminating a contract must issue a written notice of termination according to this section. The facility must also send a copy of the	01040		

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01040	Continued From page 6 termination notice to the Office of Ombudsman for Long-Term Care and, for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, to the resident's case manager, as soon as practicable after providing notice to the resident. A facility may terminate an assisted living contract only as permitted under subdivisions 3, 4, and 5. (b) A facility terminating a contract under subdivision 3 or 4 must provide a written termination notice at least 30 days before the effective date of the termination to the resident, legal representative, and designated representative. (c) A facility terminating a contract under subdivision 5 must provide a written termination notice at least 15 days before the effective date of the termination to the resident, legal representative, and designated representative. (d) If a resident moves out of a facility or cancels services received from the facility, nothing in this section prohibits a facility from enforcing against the resident any notice periods with which the resident must comply under the assisted living contract. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to issue a written notice for a termination of contract at least 30 days ahead of the termination, or at least 15 days ahead of an expedited termination, and failed to provide documentation supporting the need for an expedited termination of their contracts for two former residents (R1, R2) with records reviewed. R1's contract was terminated without notice after he broke the licensee's curfew. R2's contract was terminated without notice after he was discharged	01040		

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01040	Continued From page 7 from a local hospital. In addition, the licensee failed to send a copy of the termination notice to the Office of Ombudsman for Long Term Care (LTC). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On November 18, 2021, at 9:06 a.m., licensed assisted living director (LALD)-A stated there were two residents (R1, R2) who were discharged since the licensee transferred to an assisted living licensure on August 1, 2021. R1 R1's medical record was reviewed. R1 was admitted to the facility on July 19, 2021, under the comprehensive home care license, and began receiving assisted living services on August 1, 2021. R1's diagnoses included paranoid schizophrenia, chronic kidney disease stage 3, chronic systolic heart failure, and hypertension. R1's service plan dated July 19, 2021, indicated R1 received daily assistance with medication management and meals. Review of R1's incident report dated July 25, 2021, at 9:30 a.m., unlicensed personnel (ULP) informed LALD-A that R1 broke curfew and	01040		

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01040	Continued From page 8 "seemed inebriated." The ULP indicated empty alcohol bottles were found in the trash. The incident note indicated R1 apologized and stated he would not bring alcohol into the facility again. LALD-A told R1 he needed to leave if, "he did it again." Review of R1's progress note dated August 5, 2021, at 6:00 p.m., indicated while R1 was gone, staff entered R1's room without his knowledge and looked through his drawers and items. The progress note indicated empty alcohol bottles were found inside R1's backpack, and a "paraphernalia pipe" was found in a nightstand drawer. Review of R1's record lacked evidence staff found any drugs or full bottles of alcohol in R1's room. Review of R1's progress note dated August 5, 2021, indicated at 9:54 p.m., R1 called the facility stating he missed the last bus back to the facility and would return the following morning on August 6, 2021. Review of R1's progress note dated August 6, 2021, LALD-A told R1 he was no longer allowed to live at the facility because he broke curfew. The progress note indicated LALD-A told R1 to "pack his things." R1's social worker (SW)-C was notified. R1's record lacked evidence R1 received a written termination notice. R1's record lacked evidence a copy of the termination notice was sent to the Office of Ombudsman for LTC.	01040		

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01040	Continued From page 9 Review of an email from LALD-A to SW-C dated August 6, 2021, at 11:23 a.m., indicated R1 was not allowed back in the facility due to aggressiveness towards staff members, non-compliance with facility rules, and bringing drugs and alcohol into the facility. The email indicated R1's medications and personal belongings were left at the facility. Review of R1's record indicated R1 was without his medications for approximately 12 days, from August 6, 2021, until August 17, 2021. R1's record lacked documentation R1 created an abusive or unsafe work environment for staff providing direct cares for R1. R1's record lacked documentation supporting the need for an expedited termination of R1's contract. R1's record lacked documentation a copy of the termination notice was sent to the Office of Ombudsman for LTC. On December 29, 2021, at 12:35 p.m., SW-C stated R1's discharge, "came out of nowhere." SW-C stated she was never contacted by the facility about issues or concerns regarding R1's behaviors. On December 29, 2021, at 12:43 p.m., mental health case manager (MHCM)-D stated R1 told him the facility was "done with him" after he tried to come back to the facility after curfew. MHCM-D stated R1 did not want to go back to a facility that did not want him. MHCM-D stated between August 6, 2021, and August 17, 2021, he was unaware of R1's whereabouts, stating, "He was off our radar for a while." MHCM-D stated he did not know if know if R1 was homeless, living in a shelter, or "on the streets."	01040		

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01040	Continued From page 10 Review of R1's discharge summary, dated August 19, 2021, indicated R1 was discharged due to "needs were met." R1's discharge summary indicated R1 was transferred to a different facility. The receiving facility signature was signed by LALD-A. R1's discharge summary failed to identify the name of the facility where R1 was transferred to, and lacked specific information on how R1's needs were met which led to his discharge. Review of an undated letter indicated R1 picked up his medications and belongings on August 19, 2021. On November 18, 2021, at 9:06 a.m., LALD-A stated she was unaware where R1 moved to after being discharged from the facility even though she indicated on the discharge summary R1 was transferred to a different facility. On December 29, 2021, at 3:15 p.m., LALD-A stated the facility did not give R1 a 30-day notice of termination because he lived at the facility a short time and left on his own. LALD-A stated, "He tried to bring alcohol in the place and we told him we would terminate him if he tried to do it again." R1's record lacked evidence R1 voluntarily left the facility on his own free will. R2 R2's medical record was reviewed. R2 was admitted to the facility on June 18, 2021, under the comprehensive home care license, and began receiving assisted living services on August 1, 2021. R2's diagnoses included Type 2 diabetes mellitus, and intermittent asthma with	01040		

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01040	Continued From page 11 acute exacerbation. R2's service plan dated June 18, 2021, indicated R2 received only supportive services. R2's progress note dated August 15, 2021, indicated he was sent to the hospital for sepsis. There was no documentation if his care was transferred to the hospital. Review of R2's progress note dated August 16, 2021, indicated house manager (HM)-B instructed staff members to not accept calls from R2 when he was hospitalized after R2 called a staff member a "bitch." The progress note indicated HM-B told staff, "he doesn't need anything." Review of R2's record indicated no incident reports were completed by staff members regarding R2's behaviors. Review of R2's progress note dated August 18, 2021, at 5:02 p.m., indicated after R2's hospital discharge, HM-B dropped off R2's belongings and medications at the hospital. The progress note indicated R2 was transported to a family member's house. R2's record lacked evidence R2 received a written termination notice. R2's record lacked evidence a copy of the termination notice was sent to the Office of Ombudsman for LTC. Review of R2's undated facility discharge summary, indicated R2 was discharged due to "needs met" and discharged to a "family member."	01040		

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01040	Continued From page 12 On November 18, 2021, at 9:05 a.m., LALD-A stated R2 was considered a temporary resident until a long-term care facility was found for him. LALD-A stated R2 stole from other residents, stole from the facility, and was physically aggressive and "swearing left and right." LALD-A stated the facility "warned" R2 he would be discharged if he did not change his behaviors, stating, "Unfortunately, it didn't work out. He was suicidal, and we could no longer provide cares for him." R2's record lacked documentation R1 created an abusive or unsafe work environment for staff providing direct cares for R2. R2's record lacked documentation supporting the need for an expedited termination of R2's contract. R2's record lacked documentation a copy of the termination notice was sent to the Office of Ombudsman for LTC. The licensee policy titled, Discharge of Residents, dated August 1, 2021, indicated the licensee would provide at least 30 days advance notice of the termination of a service by the provider, except in the following situations: a. The resident engaged in conduct that altered the conditions of employment. b. The resident created an abusive or unsafe work environment for the person providing home care services. c. An emergency for the informal caregiver or significant change in resident's condition resulted in service needs exceeding the current service plan that could not be safely met by the licensee. d. The licensee did not receive payment for services, for which at least 10 days' advance notice of the termination of services would be	01040		

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NEW HOPE HEALTH CARE LLC	3812 BASS LAKE ROAD NORTH BROOKLYN CENTER, MN 55429

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01040	Continued From page 13 provided. TIME PERIOD TO CORRECT: Seven (7) days.	01040		
01070 SS=G	144G.52 Subd. 10 Right to return If a resident is absent from a facility for any reason, including an emergency relocation, the facility shall not refuse to allow a resident to return if a termination of housing has not been effectuated. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee refused to allow the return of two former residents (R1, R2) with records reviewed. R1 was not allowed to return after breaking curfew. R2 was not allowed to return after being discharged from a local hospital. 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). Findings Include: Minnesota Statute, 144G.52, Assisted Living Contract Terminations, Subd. 10, Right to Return. If a resident is absent from a facility for any reason, including an emergency relocation, the facility shall not refuse to allow a resident to return if a termination of housing has not been	01070		

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01070	Continued From page 14 effectuated. R1 R1's medical record was reviewed. R1 was admitted to the facility on July 19, 2021, under the comprehensive home care license, and began receiving assisted living services on August 1, 2021. R1's diagnoses included paranoid schizophrenia, chronic kidney disease stage 3, chronic systolic heart failure, and hypertension. R1's service plan dated July 19, 2021, indicated R1 received daily assistance with medication management and meals. Review of R1's progress note dated August 5, 2021, indicated at 9:54 p.m., R1 called the facility stating he missed the last bus back to the facility and would return the following morning on August 6, 2021. Review of R1's progress note dated August 6, 2021, licensed assisted living director (LALD)-A told R1 he was no longer allowed to live at the facility because he broke curfew. The progress note indicated LALD-A told R1 to "pack his things." R1's social worker (SW)-C was notified. R1's record lacked a written termination notice, at least 30 days in advance. Review of an email from LALD-A to SW-C dated August 6, 2021, at 11:23 a.m., indicated R1 was not allowed back in the facility due to aggressiveness towards staff members, non-compliance with facility rules, and bringing drugs and alcohol into the facility. The email indicated R1's medications and personal belongings were left at the facility.	01070		

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01070	Continued From page 15 Review of R1's record indicated no incident reports were completed by staff members regarding R1's aggressiveness towards staff members. On December 29, 2021, at 12:35 p.m., SW-C stated R1's discharge "came out of nowhere." SW-C stated she was never contacted by the facility about issues or concerns regarding R1's behaviors. On December 29, 2021, at 12:43 p.m., mental health case manager (MHCM)-D stated R1 told him the facility was "done with him" after he tried to come back to the facility after curfew. MHCM-D stated R1 did not want to go back to a facility that did not want him. MHCM-D stated between August 6, 2021, and August 17, 2021, he was unaware of R1's whereabouts, stating, "He was off our radar for a while." MHCM-D stated he did not know if know if R1 was homeless, living in a shelter, or "on the streets." On December 29, 2021, at 3:15 p.m., LALD-A stated the facility did not give R1 a 30-day notice of termination because he lived at the facility a short time and left on his own. LALD-A stated, "He tried to bring alcohol in the place, and we told him we would terminate him if he tried to do it again." R2 R2's medical record was reviewed. R2 was admitted to the facility on June 18, 2021, under the comprehensive home care license, and began receiving assisted living services on August 1, 2021. R2's diagnoses included Type 2 diabetes mellitus, and intermittent asthma with acute exacerbation.	01070		

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01070	Continued From page 16 R2's service plan dated June 18, 2021, indicated R2 received only supportive services. R2's progress note dated August 15, 2021, indicated he was sent to the hospital for sepsis. Review of R2's progress note dated August 16, 2021, indicated house manager (HM)-B instructed staff members to not accept calls from R2 when he was hospitalized after R2 called a staff member a "bitch." The progress note indicated HM-B told staff, "He doesn't need anything." Review of R2's record lacked incident reports regarding R2's behaviors. Review of R2's progress note dated August 18, 2021, at 5:02 p.m., indicated after R2's hospital discharge, HM-B dropped off R2's belongings and medications at the hospital. The progress note indicated R2 was transported to a family member's house. R2's record lacked an assessment to determine if it was appropriate for R2 to return to the facility after hospitalization. R2's record lacked a written terminate notice, 30 days in advance. Review of R2's undated facility discharge summary indicated R2 was discharged due to "needs met" and discharged to a "family member." On November 18, 2021, at 9:05 a.m., LALD-A stated R2 was considered a temporary resident until a long-term care facility was found for him. LALD-A stated R2 stole from other residents, stole from the facility, and was physically	01070		

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01070	Continued From page 17 aggressive and "swearing left and right." LALD-A stated the facility "warned" R2 he would be discharged if he did not change his behaviors, stating, "Unfortunately, it didn't work out. He was suicidal, and we could no longer provide cares for him." The licensee's undated policy titled, Minnesota Home Care Bill of Rights, indicated residents had the right to be treated with courtesy and respect, and have their property treated with respect. In addition, the licensee would provide reasonable, advanced notice of changes in services or charges, provide the reason for termination of services, and provide at least 30 calendar days advance notice of the termination of services, except in cases where: a. The recipient of services engaged in conduct that altered the conditions of employment as specified in the employment contract between the assisted living provider and the individual providing home care services, or created an abusive or unsafe work environment for the individual who provided home care services; b. an emergency for the informal caregiver or a significant change in the resident's condition resulted in service needs that exceeded the current service provider agreement and could not be safely met by the assisted living provider; or; c. the provider never received payment for services, for which at least ten days' advance notice of the termination of a service would be provided. TIME PERIOD TO CORRECT: Seven (7) days.	01070		
01130 SS=H	144G.55 Subd. 2 Safe location A safe location is not a private home where the	01130		

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01130	Continued From page 18 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 been identified. This subdivision does not preclude a resident from declining to move to the location the facility identifies. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a safe discharge location or adequate and needed service provider was identified for two former residents (R1, R2) with records reviewed. The licensee refused to allow R1 to return to the facility after he broke curfew. After not being allowed to return, R1's whereabouts were unknown for 12 days. R2 was discharged to a family member's home after the licensee refused to allow him back in the facility after being discharged from a local hospital. R2's record lacked documention verfiying an assessment was performed with R2's family member and their home to determine if R2's family member could meet R2's needs. 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).	01130		

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01130	Continued From page 19 Findings Include: 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. R1 R1's medical record was reviewed. R1 was admitted to the facility on July 19, 2021, under the comprehensive home care license, and began receiving assisted living services on August 1, 2021. R1's diagnoses included paranoid schizophrenia, chronic kidney disease stage 3, chronic systolic heart failure, and hypertension. R1's service plan dated July 19, 2021, indicated R1 received daily assistance with medication management and meals. Review of R1's progress note dated August 5, 2021, indicated at 9:54 p.m., R1 called the facility stating he missed the last bus back to the facility and would return the following morning, on August 6, 2021. Review of R1's progress note dated August 6, 2021, licensed assisted living director (LALD)-A told R1 he was no longer allowed to live at the facility because he broke curfew. The progress note indicated LALD-A told R1 to "pack his things." R1's social worker (SW)-C was notified.	01130		

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01130	Continued From page 20 Review of an email from LALD-A to SW-C dated August 6, 2021, at 11:23 a.m., indicated R1 was not allowed back in the facility due to aggressiveness towards staff members, non-compliance with facility rules, and bringing drugs and alcohol into the facility. The email indicated R1's medications and personal belongings were left at the facility. Review of R1's record indicated R1 was without his medications for approximately 12 days, from August 6, 2021, until August 17, 2021. On December 29, 2021, at 12:35 p.m., SW-C stated R1's discharge, "came out of nowhere." SW-C stated she was never contacted by the facility about issues or concerns regarding R1's behaviors. On December 29, 2021, at 12:43 p.m., mental health case manager (MHCM)-D stated between August 6, 2021, and August 17, 2021, he was unaware of R1's whereabouts, stating, "He was off our radar for a while." MHCM-D stated he did not know if know if R1 was homeless, living in a shelter, or "on the streets." MHCM-D stated on August 17, 2021, R1 ended up at a local hospital emergency room (ER) for unknown reasons. MHCM-D stated R1 entered a supportive housing residential program after he was discharged from the hospital. Review of R1's discharge summary, dated August 19, 2021, indicated R1 was discharged due to "needs were met." R1's discharge summary indicated R1 was transferred to a different facility. The receiving facility signature was signed by LALD-A.	01130		

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01130	Continued From page 21 R1's discharge summary failed to identify the name of the facility where R1 was transferred to, and lacked specific information on how R1's needs were met which led to his discharge. On November 18, 2021, at 9:06 a.m., LALD-A stated she was unaware where R1 moved to after being discharged from the facility even though she indicated on the discharge summary R1 was transferred to a different facility. On December 29, 2021, at 3:15 p.m., LALD-A stated the facility did not give R1 a 30-day notice of termination because he lived at the facility a short time and left on his own. LALD-A stated, "He tried to bring alcohol in the place, and we told him we would terminate him if he tried to do it again." R1's record lacked evidence it was R1's informed choice to voluntarily leave the facility. R2 R2's medical record was reviewed. R2 was admitted to the facility on June 18, 2021, under the comprehensive home care license, and began receiving assisted living services on August 1, 2021. R2's diagnoses included Type 2 diabetes mellitus, and intermittent asthma with acute exacerbation. R2's service plan dated June 18, 2021, indicated R2 received only supportive services. R2's progress note, dated August 15, 2021, indicated he was sent to the hospital for sepsis. Review of R2's progress note dated August 16, 2021, indicated house manager (HM)-B	01130		

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01130	Continued From page 22 instructed staff members to not accept calls from R2 when he was hospitalized after R2 called a staff member a "bitch." The progress note indicated HM-B told staff, "He doesn't need anything." Review of R2's record indicated no incident reports were completed by staff members regarding R2's behaviors. Review of R2's progress note dated August 18, 2021, at 5:02 p.m., indicated after R2's hospital discharge, HM-B dropped off R2's belongings and medications at the hospital. The progress note indicated R2 was transported to a family member's house. Review of R2's undated facility discharge summary indicated R2 was discharged due to "needs met" and discharged to a "family member." On November 18, 2021, at 9:05 a.m., LALD-A stated R2 was considered a temporary resident until a long-term care facility was found for him. LALD-A stated R2 stole from other residents, stole from the facility, and was physically aggressive and, "swearing left and right." LALD-A stated the facility "warned" R2 he would be discharged if he did not change his behaviors, stating, "Unfortunately, it didn't work out. He was suicidal, and we could no longer provide cares for him." R2's record lacked evidence the licensee performed an assessment with R2's family member and their residence to ensure the family member could meet R2's needs and services. R2's record lacked evidence it was R2's informed	01130		

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01130	Continued From page 23 choice to leave the facility. The licensee policy titled, Discharge of Residents, dated August 1, 2021, indicated the licensee would participate in a coordinated transfer of care for the resident to another home care provider, health care provider, or caregiver. TIME PERIOD TO CORRECT: Seven (7) days.	01130		
01650 SS=E	144G.70 Subd. 4 Service plan, implementation, and revisions t (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and	01650		

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01650	Continued From page 24 declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure service plans included the required content for two former residents (R1, R2) with records reviewed. 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). Findings include: R1 R1's medical record was reviewed. R1 was admitted to the facility on July 19, 2021, under the comprehensive home care license, and began receiving assisted living services on August 1, 2021. R1's diagnoses included paranoid schizophrenia, chronic kidney disease stage 3, chronic systolic heart failure, and hypertension. R1's service plan dated July 19, 2021, indicated R1 received daily assistance with medication management and meals. R1's care plan dated July 19, 2021, indicated R1 was independent with personal cares, transfers, and finances. R1 received assistance with housekeeping and laundry. R1 walked independently.	01650		

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01650	Continued From page 25 R1's service plan lacked the following information: (1) Description of the services to be provided, fees for services, and frequency of services according to R2's review, assessment, and preferences. (2) Identification of staff who provided the services. (3) Schedule and methods of monitoring staff who provided home care services. (4) Names and contact information of people R1 wished to have notified in an emergency or during any significant change to R1's condition. R2 R2's medical record was reviewed. R2 was admitted to the facility on June 18, 2021, under the comprehensive home care license, and began receiving assisted living services on August 1, 2021 R2's diagnoses included Type 2 diabetes mellitus, and intermittent asthma with acute exacerbation. R2's service plan dated June 18, 2021, indicated R2 received only supportive services. R2's care plan dated August 11, 2021, indicated R2 received assistance with medication management, laundry, and housekeeping, and needed verbal reminders for bathing, showering, and eating. R2 was independent with transfers and mobility. R2 walked independently. R2's service plan lacked the following information:	01650		

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01650	Continued From page 26 (1) Description of the services to be provided, fees for services, and frequency of services according to R2's review, assessment, and preferences. (2) Identification of staff who provided the services. (3) Schedule and methods of monitoring staff who provided home care services. On December 28, 2021, at 2:19 p.m., licensed assisted living director, (LALD)-A stated she and the facility registered nurse (RN) developed the residents' service plans. LALD-A stated she was unaware of the required content for resident service plans. The licensee policy titled, Service Plan, dated August 1, 2021, indicated an individualized service plan was implemented for all residents. The licensee would provide all services required by the current service plan. The service plan would include the following: a. A description of the services to be provided; the service description may be in the form of the resident's care plan developed with the resident or responsible party b. The fees for services and the frequency of each service, according to the resident's current review or assessment and resident preferences c. The identification of staff or categories of staff who provided the services. d. The schedule and methods of monitoring reviews or assessments of the resident.	01650		

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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
01650	Continued From page 27 e. The schedule and method of monitoring staff providing home care services or the schedule and method of supervision of staff providing the services and type of personnel who would supervise staff. f. A contingency plan that included the following: i. Action to be taken by the facility and by the resident or resident's representative if the scheduled service could not be provided. ii. Information and method for a resident or resident's representative to contact the facility. iii. Names and contact information of persons the resident wished to have notified in an emergency or if there was a significant adverse change in the resident's condition iv. Circumstances in which emergency medical services were not to be summoned and declarations made by the resident related to health care directives. The licensee policy indicated staff providing the services would be oriented to the written service plan. TIME PERIOD TO CORRECT: Seven (7) days.	01650		
01730 SS=E	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for	01730		

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	36404	A. BUILDING: _____ B. WING _____	C 11/18/2021

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01730	Continued From page 28 each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure resident service plans and records included a written statement of the medication management	01730		

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01730	Continued From page 29 services that would be provided. This affected two of two former residents (R1, R2) records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 R1's medical record was reviewed. R1 was admitted to the facility on July 19, 2021, under the comprehensive home care license, and began receiving assisted living services on August 1, 2021. R1's diagnoses included paranoid schizophrenia, chronic kidney disease stage 3, chronic systolic heart failure, and hypertension. R1's service plan dated July 19, 2021, indicated R1 received daily assistance with medication management and meals. R1's medication administration record dated August 2021, indicated R1 was prescribed and administered the following medications: spironolcatone, 25 milligrams (mg), one tablet by mouth (PO) daily (8am); amlodipine besylate, 10 mg, one tablet PO daily (8am); Entresto extended control (EC), 97 mg/103 mg, two tablets PO, twice daily (8am, 1pm); carvedilol EC, 25 mg, two tablets, (50 mg), PO twice daily (8am, 8pm); famotidine, 20 mg tablet, one tablet, (PO), daily	01730		

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01730	Continued From page 30 (8am); aripiprazole 30 mg, 1/2 tablet (15 mg), PO, daily (8am); potassium chloride, 20 milliequivalents (mEq), extended release (ER), PO, two tablets, (40 mEq), daily (8am); furosemide 20 mg, two tablets (40 mg) PO daily (8am), and one tablet (20 mg) in the afternoon (1pm); risperidone 3 mg, PO, at bedtime (HS) (8pm); xarelto 20 mg, one tablet (PO) with evening meal, (6pm). Review of R1's progress note dated August 5, 2021, indicated at 9:54 p.m., R1 called the facility stating he missed the last bus back to the facility and would return the following morning on August 6, 2021. Review of R1's progress note dated August 6, 2021, licensed assisted living director (LALD)-A told R1 he was no longer allowed to live at the facility because he broke curfew. The progress note indicated LALD-A told R1 to "pack his things." R1's social worker (SW)-C was notified. Review of R1's record indicated R1 was without his medications for approximately 12 days, from August 6, 2021, until August 17, 2021. Review of the Mayo Clinic website, mayoclinic.org, indicated the following side effects from missed doses of medications R1 was prescribed but missed for 12 days: -spironolactone- increased body edema (swelling), high blood pressure, increased risk of heart failure and stroke; -amlodipine besylate-high blood pressure-increased risk of heart attack, heart failure, and stroke; -Entresto-increased risk of death from heart failure and heart attack;	01730		

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01730	Continued From page 31 -carvedilol-increased risk of experiencing severe chest pain, heart attack, and irregular heartbeat; -aripiprazole-increased abnormal body movements, tachycardia (fast heartbeat), nausea, and anxiety; -potassium chloride-weakness, fatigue, muscle cramps, and abnormal heart rhythms; -furosemide-increased edema and heart failure; -risperidone-increase in psychotic symptoms (delusions, hallucinations, insomnia, irritability); -xarelto-incresed risk of devloping blood clots R1's service plan lacked the following information: -statements describing the medication management services provided; -a description of storage of medications based on the resident's needs and preferences, and risk of diversion consistent with the manufacturer's directions; -documentation of specific resident instructions relating to the administration of medications; -identification of persons responsible for monitoring medication supplies and ensuring refills were ordered on a timely basis; -identification of medication management tasks that may be delegated to unlicensed personnel; -procedures for staff notifying a registered nurse (RN) or appropriate licensed heath professional when problems arose with medication management services; -specific resident requirements related to documenting medication administration, verifications all medications were administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. R2	01730		

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01730	Continued From page 32 R2's medical record was reviewed. R2 was admitted to the facility on June 18, 2021 under the comprehensive home care license, and began receiving assisted living services on August 1, 2021. R2's diagnoses included Type 2 diabetes mellitus, and intermittent asthma with acute exacerbation. R2's service plan dated June 18, 2021, indicated R2 required no services, only needing assistance with shopping and supplies provided by an outside home health agency. R2's care plan dated August 11, 2021, indicated R2 received assistance with medication management, and supportive services which included laundry, housekeeping, and verbal reminders for bathing, showering, and eating. R2 was independent with transfers and mobility. R2 walked independently. R2's medication administration record (MAR) dated August 2021, indicated R2 was prescribed and administered the following medications: duloxetine delayed release (DR), 30 mg, one tablet PO daily (8am); tamsulosin, 0.4 mg, one capsule PO twice daily (8am, 8pm); gabapentin 800 mg, one tablet PO three times daily, (8am., 1pm, 8pm.); buproprion 300 mg extended release (XL), one tablet PO daily (8am); trazadone 100 mg, two tablets PO daily, HS (8pm.); flovent hydrofluoralkane (HFA), 110 micrograms (mcg) oral inhalation, inhale one puff into lungs twice daily (1pm, 8pm). R2's service plan lacked the following information: -statements describing the medication management services provided;	01730		

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01730	Continued From page 33 -a description of storage of medications based on the resident's needs and preferences, and risk of diversion consistent with the manufacturer's directions; -documentation of specific resident instructions relating to the administration of medications; -identification of persons responsible for monitoring medication supplies and ensuring refills were ordered on a timely basis; -identification of medication management tasks that may be delegated to unlicensed personnel; -procedures for staff notifying a registered nurse (RN) or appropriate licensed health professional when problems arose with medication management services; -specific resident requirements related to documenting medication administration, verifications all medications were administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. On December 28, 2021, at 2:19 p.m., licensed assisted living director, (LALD)-A verified R1 and R2's service plans did not have an individualized medication management plan. The licensee policy titled, Assessment for Medication Management Program, dated August 1, 2021, indicated prior to providing medication management services, the licensee would provide an assessment by a registered nurse, (RN), licensed health professional, or authorized prescriber to determine what medication management services would be provided and how they were implemented. Based on the results of the assessments, the clinician would document an individualized medication management plan which included the following elements:	01730		

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01730	Continued From page 34 i. description of provided medication management services; ii. description of medication storage based on resident need, preference, risk of diversion and per manufacturer's direction; iii. documentation procedures; iv. procedures for verification that medications were administered as prescribed; v. procedures for monitoring medication used to prevent complications or adverse reactions; vi. identification of person(s) responsible for monitoring medication supplies and ensuring refills were ordered in a timely manner; vii. identification of medication management tasks delegated to unlicensed staff; viii. procedures for notifying the RN or licensed health profession regarding problems that arose with medication management services. TIME PERIOD TO CORRECT: Seven (7) days.	01730		
02350 SS=E	144G.91 Subd. 7 Courteous treatment Residents have the right to be treated with courtesy and respect, and to have the resident's property treated with respect. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure two former residents (R1, R2) with records reviewed, were treated with courtesy and respect. R1 was not allowed access to his belongings and medications for 12 days after the licensee refused to allow R1 back into the facility after he broke curfew. R2 was not allowed to return to the facility after being	02350		

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02350	Continued From page 35 discharged from a hospital. R2's belongings were dropped off at the hospital. 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). Findings Include: R1 R1's medical record was reviewed. R1 was admitted to the facility on July 19, 2021, under the comprehensive home care license, and began receiving assisted living services on August 1, 2021. R1's diagnoses included paranoid schizophrenia, chronic kidney disease stage 3, chronic systolic heart failure, and hypertension. R1's service plan dated July 19, 2021, indicated R1 received daily assistance with medication management and meals. Review of R1's progress note dated August 5, 2021, indicated at 9:54 p.m., R1 called the facility stating he missed the last bus back to the facility and would return the following morning on August 6, 2021. Review of R1's progress note dated August 6, 2021, licensed assisted living director (LALD)-A told R1 he was no longer allowed to live at the facility because he broke curfew. The progress note indicated LALD-A told R1 to "pack his things." R1's social worker (SW)-C was notified.	02350		

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02350	Continued From page 36 Review of an email from LALD-A to SW-C dated August 6, 2021, at 11:23 a.m., indicated R1 was not allowed back in the facility due to aggressiveness towards staff members, non-compliance with facility rules, and bringing drugs and alcohol into the facility. The email indicated R1's medications and personal belongings were left at the facility. Review of R1's record indicated R1 was without his medications and belongings from August 6, 2021, until August 19, 2021. Review of an undated letter indicated R1 picked up his medications and belongings on August 19, 2021. On December 29, 2021, at 12:43 p.m., mental health case manager (MHCM)-D stated R1 told him the facility was "done with him" after he tried to come back to the facility after curfew. MHCM-D stated R1 did not want to go back to a facility that did not want him. MHCM-D stated between August 6, 2021, and August 17, 2021, he was unaware of R1's whereabouts, stating, "He was off our radar for a while." MHCM-D stated he did not know if know if R1 was homeless, living in a shelter, or "on the streets." R2 R2's medical record was reviewed. R2 was admitted to the facility on June 18, 2021, under the comprehensive home care license, and began receiving assisted living services on August 1, 2021. R2's diagnoses included Type 2 diabetes mellitus, and intermittent asthma with acute exacerbation. R2's service plan dated June 18, 2021, indicated	02350		

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02350	Continued From page 37 R2 received only supportive services. R2's progress note, dated August 15, 2021, indicated he was sent to the hospital for sepsis. Review of R2's progress note dated August 16, 2021, indicated house manager (HM)-B instructed staff members to not accept calls from R2 when he was hospitalized after R2 called a staff member a "bitch." The progress note indicated HM-B told staff, "He doesn't need anything." Review of R2's progress note dated August 18, 2021, at 5:02 p.m., indicated after R2's hospital discharge, HM-B dropped off R2's belongings and medications at the hospital. The progress note indicated R2 was transported to a family member's house. Review of R2's undated facility discharge summary indicated R2 was discharged due to "needs met" and discharged to a "family member." On November 18, 2021, at 9:05 a.m., LALD-A stated R2 was considered a temporary resident until a long-term care facility was found for him. The licensee's undated policy titled, Minnesota Home Care Bill of Rights, indicated residents had the right to be treated with courtesy and respect, and have their property treated with respect. No further information was provided. TIME PERIOD TO CORRECT: Seven (7) days.	02350		

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02370	Continued From page 38	02370		
02370 SS=E	144G.91 Subd. 9 Right to come and go freely Residents have the right to enter and leave the facility as they choose. This right may be restricted only as allowed by other law and consistent with a resident's service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to allow one of two residents (R1) with records reviewed, the right to come and go freely. R1 was not allowed to return to the facility after he broke their curfew. 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 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). Findings Include: Minnesota Statute, 144G.91, Assisted Living Bill of Rights, Subd. 9. Right to come and go freely. Residents have the right to enter and leave the facility as they choose. This right may be restricted only as allowed by other law and consistent with the resident's service plan. R1 R1's medical record was reviewed. R1 was admitted to the facility on July 19, 2021, under the comprehensive home care license, and began receiving assisted living services on August 1, 2021. R1's diagnoses included paranoid schizophrenia, chronic kidney disease stage 3,	02370		

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02370	Continued From page 39 chronic systolic heart failure, and hypertension. R1's service plan dated July 19, 2021, indicated R1 received daily assistance with medication management and meals. Review of R1's progress note dated August 5, 2021, indicated at 9:54 p.m., R1 called the facility stating he missed the last bus back to the facility and would return the following morning, on August 6, 2021. Review of R1's progress note dated August 6, 2021, licensed assisted living director (LALD)-A told R1 he was no longer allowed to live at the facility because he broke curfew. The progress note indicated LALD-A told R1 to "pack his things." R1's social worker (SW)-C was notified. Review of an email from LALD-A to SW-C dated August 6, 2021, at 11:23 a.m., indicated R1 was not allowed back in the facility due to aggressiveness towards staff members, non-compliance with facility rules, and bringing drugs and alcohol into the facility. The email indicated R1's medications and personal belongings were left at the facility. R1's whereabouts were unknown from August 6, 2021, through August 17, 2021. On November 18, 2021, at 9:06 a.m., LALD-A stated she was unaware of where R1 moved to after the facility refused to allow him to return. The facility did not provide a policy on a resident's right to come and go freely. No further information was provided.	02370		

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02370	Continued From page 40 TIME PERIOD TO CORRECT: Seven (7) days.	02370		