STATE LICENSING COMPLIANCE REPORT

Report #: HL347588221C **Date Concluded:** March 4, 2025

Name, Address, and County of Facility Investigated:
Mission Hill Group Home Services
2722 North 4th Street
Minneapolis MN, 55411
Hennepin County

Facility Type: Assisted Living Facility (ALF) **Evaluator's Name:** Kris Detsch, 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
	34758	A. BUILDING: _____ B. WING _____	C 02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSION HILL GROUP HOME SRVS	2722 NORTH 4TH STREET MINNEAPOLIS, MN 55411

(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 ******ATTENTION****** ASSISTED LIVING PROVIDER 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: HL347588221C On February 28, 2025, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction order is issued. At the time of the complaint investigation, there were three residents receiving services under the provider's Assisted Living license. The following immediate correction order is issued. The following immediate correction order is issued for HL347588221C, tag identification 250.	0 000	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. 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.	
0 250 SS=I	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a	0 250		

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0 250	Continued From page 1 provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or staff of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or staff; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under	0 250		

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0 250	Continued From page 2 section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to fully cooperate with the investigation by failing to provide requested records, including consultant information, resident records and records to show they submitted updated emergency relocation plans to the Minnesota Department of Health (MDH) after they relocated to an unlicensed home from a hotel for three of three residents (R1, R2, R3) with record reviewed. Due to lack of information, it cannot be determined if the residents were receiving required services, if the new location appeared to be safe and appropriate and if any behavior interventions were in place to mitigate fire risks. 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	0 250		

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0 250	Continued From page 3 portion or all of the residents). The findings include: On February 18, 2025, at 4:04 p.m., owner (OW)-A informed MDH the licensee moved three residents to a hotel. The licensee facility sustained a fire and planed to move back to the location after the licensee re-built. On February 20, 2025, at 8:51 a.m., an MDH engineer provided an email with an update of the facility site visit. The MDH engineer indicated it was not possible to the enter the building due to the fire damage. The fire started in the second floor bedroom. The city official was also present to determine if the property needed an order for repair or removal. The MDH engineer indicated he spoke with OW-A on the phone who stated the fire started at 2:00 a.m., the smoke alarms alerted the residents and the employee on duty. The employee on duty had a facetime video when occupants went out the front door showing the window of the room of fire origin had already broke and fire was present. The MDH engineer indicated he request a copy of the fire report when OW-A receives it and the video. On February 20, 2025, at 1:46 p.m., OW-A sent MDH a letter indicating the licensee sustained a fire on February 18, 2025, at approximately 2:00 a.m., and relocated their residents to a local hotel. The letter OW-A planed to relocate the residents to another "facility" in the next few days. On February 27, 2025, an updated received from the MDH engineer indicated OW-A had not provided any further information, including the fire report and video. The MDH engineer was going to contact OW-A and look into contacting the fire	0 250		

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0 250	Continued From page 4 investigator for the report, but the fire investigation could take a while before releasing a report. On February 28, 2025, at 8:06 a.m., the investigator called OW-A and left a message for her to return the call. On February 28, 2025, at 12:41 p.m., the investigator went to the hotel address and was unable to locate OW-A. OW-A checked out of the hotel on February 25, 2025, at 10:51 a.m. On February 28, 2025, at 2:11 p.m., the investigator sent OW-A an email and requested her to contact the investigator as OW-A had not returned the investigator's phone call. On February 28, 2025, at 2:13 p.m., OW-A called the investigator and said all residents moved from the hotel to an unlicensed "house" and provided the address on Tuesday February 25, 2025. OW-A said eventually one resident left the house (R3) and went home with family. OW-A said she did not have any resident records and was unable to back up records due to water damage. OW-A said some records were paper, some were electronic. OW-A said she sent MDH relocation notices. The investigator asked OW-A to send/forward the information to the investigator. OW-A said the licensee used an electronic medical record system and the investigator told OW-A she would request resident records from the electronic system. On February 28, 2025, at 3:05 p.m., the investigator sent OW-A an email requesting resident records including a face sheet, service plan, care plan, most recent full nursing assessment, and February progress notes.	0 250		

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0 250	Continued From page 5 Additionally, the investigator requested the name/contact information of the staff member who worked at the time of the fire, incident report/documentation regarding the fire, and staff roster. On March 4, 2025, at 10:10 a.m., the investigator sent OW-A an email and requested resident records to be sent by end of business day (March 4, 2025). On March 4, 2025, at 10:35 a.m., the investigator called OW-A and left a message for her to return the call. On March 4, 2025, at 12:07 p.m., OW-A called the surveyor and said the licensee planned to rebuild the structure burned by the fire. OW-A said she would talk with a consultant to decide what to do with licensure. OW-A said she was trying to figure everything out and thought MDH would give licensure to another house, or close licensure for the structure burned. OW-A said she would call the consultant but was unsure the name of the consultant. OW-A said the consultant received "something" from Department of Human Services (DHS), but she was unsure of what it was. OW-A said she would know more by Friday (March 7, 2025). OW-A acknowledged she did not provide resident documentation to the investigator and requested an extension until Friday (March 7, 2025) to send the requested records and name of the consultant because she did not have Wi-Fi services. TIME PERIOD OF CORRECTION: IMMEDIATE	0 250		