STATE LICENSING COMPLIANCE REPORT

Report #: HL359884660C

Date Concluded: February 7, 2024

Name, Address, and County of Facility Investigated:
Noah Home Care Inc
13521 Nicollet Lane
Burnsville, MN 55337
Dakota County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Barbara Axness, 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
	35988	A. BUILDING: _____ B. WING _____	C 02/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOAH HOME CARE INC	13521 NICOLLET LANE BURNSVILLE, MN 55337

(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: #HL359884660C On February 7, 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 two residents receiving services under the provider's Assisted Living license. The following correction orders are issued for #HL359884660C, tag identification 1060, 1070.	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 License 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 subd. 1, 2, and 3.	
01060 SS=D	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a	01060		

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01060	Continued From page 1 resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process	01060		

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01060	Continued From page 2 in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with required content to the resident, legal representative, and designated representative; and failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) when the resident did not return from the emergency relocation within four days for one of one resident (R1). 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 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: R1's diagnoses included paranoid schizophrenia, anxiety, and substance use disorder. R1's record lacked a signed service plan. R1's record contained an undated emergency relocation notice which indicated the resident was relocated to the hospital on July 31, 2023 due to a mental health crisis. R1's record lacked evidence of who received the emergency relocation notice. R1's progress notes indicated on July 31, 2023, "The client has been on and off from our facility as from 07/19 and has been missing medications	01060		

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01060	Continued From page 3 including his Invega injection (an antipsychotic medication used to treat schizophrenia). He came back home today and was hallucinating, screaming, yelling, and aggressive to both staff and other clients. Staff were unable to calm him down and called the manager who called 911 because of safety. The client was taken to [hospital] for evaluation and treatment...(sic)" A progress note indicated the resident discharged on August 17, 2023. The police report indicated officers arrived to the facility on July 31, 2023, at 9:20 p.m. for a mental health crisis call. House manager (HM)-A informed officers the resident had been suicidal on July 28, 2023, and had not been taking his medications since then and needed to be taken to the hospital. The resident was observed to be verbally aggressive with staff and "appears to be suffering from a schizophrenia episode." HM-A asked officers to transport the resident to the hospital "for his own welfare." The resident initially refused to cooperate with officers and medics and became combative towards the officers. The resident had to be restrained and handcuffed. R1's record lacked a written notice that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident had been relocated and any new service provider; - contact information for the OOLTC; - if known and applicable, the approximate date or range of dates within which the resident was expected to return to the facility, or a statement that a return date is not currently known; - a statement that, if the facility refuses to provide housing or services after a relocation, the	01060		

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01060	Continued From page 4 resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. In addition, R1's record lacked notification to the OOLTC that the resident had been relocated and had not returned to the facility within four days. On February 6, 2024, at 2:05 p.m., R1's mother stated they did not receive any written termination notices or any information related to his right to return. R1's mother stated, "I think they were just ready to move on and be able to have another client, I think they just wanted to have the space for another client." R1's mother stated facility management had told her "we can't keep [R1] here...and they did talk to me about that they weren't going to continue to have [R1] there." On February 7, 2024, at 8:40 a.m., licensed assisted living director/registered nurse (LALD/RN)-D stated he was not sure if an emergency relocation notice was completed. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01060		
01070 SS=D	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	01070		

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01070	Continued From page 5 by: Based on interview and record review, the licensee failed to allow the return of one of one resident (R1) after they were sent to the emergency room, although the licensee had not issued a notice of termination of services or housing. Hospital records indicated the licensee would not accept R1 back after being medically cleared to return. The licensee failed to offer any option for R1 to return as a housing-only resident with the necessary services provided by another agency. The resident had to stay in the hospital despite being medically cleared for discharge while he waited for other placement. 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). The findings include: R1's diagnoses included paranoid schizophrenia, anxiety, and substance use disorder. R1's record lacked a signed service plan. R1's assessment dated July 29, 2023, indicated the resident could be physically and verbally aggressive towards staff and other residents, would experience visual and voice hallucinations, and had anxiety that required redirection. R1's progress notes indicated on July 31, 2023, "The client has been on and off from our facility as from 07/19 and has been missing medications	01070		

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01070	Continued From page 6 including his Invega injection (an antipsychotic medication used to treat schizophrenia). He came back home today and was hallucinating, screaming, yelling, and aggressive to both staff and other clients. Staff were unable to calm him down and called the manager who called 911 because of safety. The client was taken to [hospital] for evaluation and treatment...(sic)" A progress note indicated the resident discharged on August 17, 2023. A progress note from August 17, 2023, indicated "...When he [R1] was at the hospital the writer made a safe return plan that included 1"1 staffing. This was due to safety of all clients [residents]/staff. The manager had a virtual meeting with his social worker, case manager, amd mum (sic) and communicated this plan of 1:1 to them for his safe return home. Also he gave them a list of other facilities which had openings. The manager started looking for additional staff and communicated this to the case manger for approval. The manager later received communication from the case manager that they have agreed with the client mum (sic) who is a legal guardian that they have found another facility that can take care of the client [resident] The client [resident] came to our facility today to pick up his personal belongings and medications..." The police report indicated officers arrived to the facility on July 31, 2023, at 9:20 p.m. for a mental health crisis call. House manager (HM)-A informed officers the resident had been suicidal on July 28, 2023, and had not been taking his medications since then and needed to be taken to the hospital. The resident was observed to be verbally aggressive with staff and "appears to be suffering from a schizophrenia episode." HM-A asked officers to transport the resident to the hospital "for his own welfare." The resident	01070		

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01070	Continued From page 7 initially refused to cooperate with officers and medics and became combative towards the officers. The resident had to be restrained and handcuffed. On February 6, 2024, at 1:40 p.m., the resident's case manager (CM)-B stated, "The provider made it pretty clear for a while they did not want him to stay there. They had not issued any intent to terminate services or anything like that but they had mentioned [terminating services] and talked about it so when he went to the hospital, they felt like if they didn't let him come back, he doesn't have to be here." CM-B stated they had tried working with the facility to accept the resident back so he didn't have to stay in the hospital but, "The provider was not very accommodating. I understand he's difficult, but they were going out of their way to make him not want to stay there." On February 6, 2024, at 2:05 p.m., R1's mother stated they did not receive any written termination notices or any information related to his right to return. R1's mother stated, "I think they were just ready to move on and be able to have another client, I think they just wanted to have the space for another client." R1's mother stated facility management had told her "we can't keep [R1] here...and they did talk to me about that they weren't going to continue to have [R1] there." R1's mother stated the facility didn't seem equipped to manage R1's care and that staff didn't seem to be trained on how to handle mental health clients. R1's mother stated that it seemed like "a lot of the group homes [assisted living facilities], they just start a group home [assisted living facility] because of the income it generates for them but I really believe that they need to have a staff with mental health certification. I was constantly telling the staff how to interact with	01070		

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01070	Continued From page 8 [R1]. He has schizophrenia, if he says a profanity, it's not at you it's to the voices that are harassing him. Just ignore it, he's not saying that to you. He might walk by you and say a profanity but it's not to you." R1's mother stated she had been to the facility a few times and had to get between facility staff and the resident and help them understand his behaviors. On February 7, 2024, at 8:40 a.m., licensed assisted living director/registered nurse (LALD/RN)-D stated the facility did not consider it an inappropriate discharge as the facility was not able to control his mental health and the resident was not taking his medications. LALD/RN-D stated the resident came back to the facility one day and he refused to take his medications and began hallucinating and had a mental crisis and was sent to the hospital. LALD/RN-D stated the facility was in the process of adding more staff to take the resident back but the resident chose to go somewhere else. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01070		