DEPARTMENT OF HUMAN SERVICES

March 7, 2025

Sharmaine Meadows, Authorized Agent
Cradle of Love LLC
1680 Suburban Avenue
Saint Paul, MN 55106-6632

License Number: 1103582 (245D – HCBS)
Report Number: 202410941

CORRECTION ORDER

Dear Sharmaine Meadows:

On January 27, 2025, a licensing review and investigation of Cradle of Love LLC, located at 1680 Suburban Avenue, Saint Paul, Minnesota, was conducted to determine compliance with state and federal laws and rules governing the provision of home and community-based services to persons with disabilities and age 65 and older under Minnesota Statutes, Chapter 245D. As a result of this licensing review a Correction Order is being issued.

A. Reason for Correction Order

Pursuant to Minnesota Statutes, section 245A.06, if the Commissioner of the Department of Human Services (DHS) finds that the license holder has failed to comply with an applicable law or rule and this failure does not imminently endanger the health, safety, or rights of the persons served by the program, the Commissioner may issue a Correction Order to the license holder.

The following violation(s) of state or federal laws and rules were determined as a result of the licensing review. Corrective action for each violation is required by Minnesota Statutes, section 245A.06 and is hereby ordered by the Commissioner of Human Services.

1. Citation: Minnesota Statutes, section 245D.081.

Violation: The license holder did not meet the requirements of program coordination, evaluation and oversight.

a. The license holder failed to ensure the designated coordinator (SP3), provided supervision, support, and evaluation of activities that include:
   - oversight of the license holder's responsibilities assigned in the persons support plan and support plan addendum;
   - taking the action necessary to facilitate the accomplishment of the outcomes according to the requirements in section 245D.07;

- instruction and assistance to direct support staff implementing the support plan and the service outcomes, including direct observation of service delivery sufficient to assess staff competency; and
- evaluation of the effectiveness of services delivery, methodologies, and progress on the person's outcomes based on the measurable and observable criteria for identifying when the desired outcomes based on the measurable and observable criteria for identifying when the desired outcome has been achieved according to the requirements in section 245D.07.

b. The license holder failed to ensure that the designated manager (SP4) provided program management and oversight of the services provided by the license holder that include:
   - maintaining a current understanding of the licensing requirements sufficient to ensure compliance throughout the program as identified in section 245A.04, subdivision 1, paragraph (e), and when applicable, as identified in section 256B.04, subdivision 21, paragraph (g);
   - ensuring the duties of the designated coordinator are fulfilled according to the requirements in subdivision 2;
   - evaluation of satisfaction of persons served by the program, the person's legal representative, if any, and the case manager with the service delivery and progress towards accomplishing outcomes identified in section 245D.07 and 245D.071 and ensuring and protecting each person's rights as identified in section 245D.04;
   - ensuring staff competency requirements are met according to the requirements in section 245D.09, subdivision 3, and ensuring staff orientation and training is provided according to the requirements in section 245D.09, subdivision 4, 4a and 5;
   - ensuring corrective action was taken when ordered by the commissioner; and
   - evaluating the information identified in clauses (1) to (6) to develop, document, and implement ongoing program improvements.

   See citations 2 through 10 as evidence of the license holder's failure to ensure that the designated coordinator and designated manager fulfilled the requirements detailed above.

Repeat Violation: In a Correction Order that DHS issued on September 13, 2024, you were previously found in violation of this same statute

Corrective Action Ordered: Within 30 days of receiving this order, you must:
- review this order with SP3 and SP4;
- compete all corrective action in the timeline stated for each violation in this order; and
- maintain documentation of the corrective action completed at the program for review by DHS.

On an ongoing basis, you must maintain compliance with all applicable laws and rules of your license.

2. Citation: Minnesota Rule 9544.0030, subpart 1.

Violation: For two of three persons whose record was reviewed (P1 and P3), the license holder did not incorporate positive support strategies as required.

The license holder determined changes were needed in the positive support strategies the license holder used with P1 and P3; however, the license holder failed to incorporate the identified positive support strategies for P1 and P3 in writing to the existing treatment, service, or other individual plans for P1 and P3.

Repeat Violation: In a Correction Order that DHS issued on September 13, 2024, you were previously found in violation of this same statute

Corrective Action Ordered: At the time of the licensing review, P3 was no longer receiving services from the license holder. Immediately, you must incorporate P1's current and appropriate positive support strategies in writing to P1's existing treatment, service or other individual plans. On an ongoing basis, you must maintain compliance as required in this subpart.

3. Citation: Minnesota Statutes, section 245D.05, subdivision 1, paragraph (b).

Violation: For one person whose record was reviewed (P1), the license holder did not maintain documentation of health service needs as required.

The license holder was assigned responsibility for meeting P1's health needs according to P1's support plan addendum. P1 was prescribed a pro re nata (PRN) psychotropic medication. The license holder failed to maintain documentation on how P1's health needs would be met, including a description of the procedures the license holder would follow in order to administer P1's psychotropic PRN medication.

Corrective Action Ordered: Immediately, you must maintain documentation in P1's support plan addendum that includes a description of the procedures you will follow in order to administer P1's psychotropic PRN medication. On an ongoing basis, you must maintain compliance as required in this subdivision.

4. Citation: Minnesota Statutes, section 245D.05, subdivision 2.

Violation: For one person whose record was reviewed (P1), the license holder did not implement medication administration procedures as required.

The license holder was assigned responsibility for administering P1's medications according to P1's support plan addendum. The license holder failed to implement medication administration procedures, including:

- notation of any occurrence of a dose of medication not being administered as prescribed, whether by error by the staff or the person or by refusal by the person, or of adverse reactions, and when and to whom the report was made; and
- notation of when a medication was administered.

The license holder's failure to implement medication administration procedures was evident as the license holder failed to include notation of one or more medications on the following dates in P1's medication administration record:

- November 2, 3, 8, and 30, 2024;
- December 1, 6, 7, 8, 13-16, 18, 25, 27, 28, and 31, 2024; and
- January 1, 2, 4-7, 11, 13-16, 18, 20-22, and 25, 2025.

Repeat Violation: In a Correction Order that DHS issued on September 13, 2024, you were previously found in violation of this same statute

Corrective Action Ordered: On an ongoing basis, you must maintain compliance as required in this subdivision.

5. Citation: Minnesota Rule 9544.0110.

Violation: For two persons whose records were reviewed (P1 and P3), the license holder did not report the use of restrictive interventions and incidents as required.

a. The license holder failed to submit a behavior intervention report form to the commissioner to report behavioral incidents involving P1 that resulted in calling 911 on the following dates:
   - November 24, 2024
   - December 1, 2024;
   - December 7, 2024;
   - December 14, 2024; and
   - January 6, 2025.

b. The license holder failed to submit a behavior intervention report to the commissioner to report behavioral incidents involving P3 that resulted in calling 911 on the following dates:
   - December 28, 2024; and
   - December 29, 2024.

Corrective Action Ordered: Immediately, you must submit behavior intervention reports to the commissioner for the behavioral incidents involving P1 and P3 as mentioned above. On an ongoing basis, you must maintain compliance as required in this subdivision.

6. Citation: Minnesota Statutes, section 245D.061, subdivisions 5, 6, 7, 8, and 9.

Violation: For two persons whose records were reviewed (P1 and P3), the license holder did not ensure that an emergency use of manual restraint complied with this chapter and the license holder's policy and procedures as required.

The license holder's policy and procedures on the emergency use of manual restraints stated that the license holder did not allow the emergency use of manual restraints and that

alternative measures must be used by staff to achieve safety when a person's conduct poses imminent risk of physical harm to self or others. The license holder failed to implement the policy and procedures on the following dates:

- January 6, 2025, when SP1 used a manual restraint during an incident involving P1; and
- December 29, 2024, when an unidentified staff used a manual restraint during an incident involving P3.

The license holder also failed to:

- ensure within three calendar days after the emergency use of manual restraint, that the staff person who implemented the emergency use reported in writing to the designated coordinator information about the emergency use according to subdivision 5;
- complete and document an internal review within five working days the emergency use of manual restraint according to subdivision 6;
- consult with P1's and P3's expanded support team within five working days after the completion of the internal review as required under subdivision 7; and
- submit the required documentation to the Department of Human Services and the Office of the Ombudsman for Mental Health and Developmental Disabilities within five working days of the expanded support team review according to subdivision 8.

Corrective Action Ordered: At the time of the licensing review, P3 was no longer receiving services from the license holder. Within 30 days of receiving of this order, you must:

- have the staff person who implemented the emergency use report in writing to the designated coordinator information about the emergency use according to subdivision 5;
- complete and document an internal review of the emergency use of manual restraints involving P1 and P3 according to subdivision 6;
- consult with P1's expanded support team within five working days after the completion of the internal review as required under subdivision 7; and
- submit the required documentation to the Department of Human Services and the Office of the Ombudsman for Mental Health and Developmental Disabilities for the emergency uses of manual restraint involving P1 and P3 according to subdivision 8.

On an ongoing basis, you must maintain compliance throughout your program as required in these subdivisions.

7. Citation: Minnesota Statutes, section 245D.07, subdivision 1.

Violation: For two persons whose records were reviewed (P1 and P2), the license holder did not provide services in compliance with this chapter and the federal waiver plans as required.

The license holder provided crisis respite services to P1 and P2. The Community-Based Services Manual (CBSM) states the following activities for crisis respite services are covered, however, the license holder failed to perform these activities for P1 and P2:

- assess the person and situation to determine the factors causing the crisis;

- develop a person-centered intervention plan, in coordination with the person and support team, that is based on recommendations in the assessment; and
- recommend positive support strategies and revisions to the person's support plan to prevent or minimize future crisis situations and increase the stability of the person living in the community.

Repeat Violation: In a Correction Order that DHS issued on September 13, 2024, you were previously found in violation of this same statute.

Corrective Action Ordered: Immediately, you must:

- perform the activities detailed above for P1 and P2;
- audit the services provided to all persons receiving crisis respite services; and
- for persons that you have not performed the activities detailed in the CBSM, you must perform and document the activities within 10 calendar days of receiving this order.

On an ongoing basis, you must maintain compliance as required in this subdivision.

8. Citation: Minnesota Statutes, section 245D.11, subdivision 1 and subdivision 2, clause (3).

Violation: For one person whose record was reviewed (P1), the license holder did not enforce the safe medication assistance and administration policy and procedures as required.

The license holder failed to enforce the license holder's medication administration policy and procedures. The license holder maintained a policy and procedures titled, "Safe Medication Assistance and Administration." The policy documented that the license holder was responsible for coordinating medication refills. The license holder failed to do so when two of P1's psychotropic medications were not refilled and were unavailable to be administered to P1 on November 12 – 24, 2024.

Corrective Action Ordered: On an ongoing basis, you must maintain compliance as required in this subdivision.

9. Citation: Minnesota Statutes, section 245A.65, subdivision 3.

Violation: For two of three staff persons whose records were reviewed (SP1-SP2), the license holder did not provide orientation on the license holder's program abuse prevention plan (PAPP) as required.

The license holder failed to provide SP1 and SP2 orientation on the license holder's PAPP within 72 hours of first providing direct contact services and annually thereafter.

Corrective Action Ordered: Immediately, you must provide SP1 and SP2 orientation on your PAPP. On an ongoing basis, you must maintain compliance as required in this subdivision.

10. Citation: Minnesota Statutes, section 245D.09, subdivision 4 and section 245D.081, subdivision 3.

Violation: For one staff person whose record was reviewed (SP2), the license holder did not provide orientation training as required.

The license holder failed to provide SP2 orientation to basic first aid within 60 days of hire.

Repeat Violation: In a Correction Order that DHS issued on September 13, 2024, you were previously found in violation of this same statute.

Corrective Action Ordered: Immediately, you must provide SP2 with orientation to basic first aid. On an ongoing basis, you must maintain compliance as required in this subdivision.

11. Citation: Minnesota Statutes, section 245D.09, subdivision 5.

Violation: For one staff person whose record was reviewed (SP1), the license holder did not provide annual training as required.

Minnesota Statutes, section 245A.02, subdivision 2b defines "annual" or "annually" to mean prior to or within the same month of the subsequent calendar year.

The license holder failed to provide annual training to SP1 on the following topics:

- data privacy requirements according to sections 13.01 to 13.10 and 13.46, the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), and staff responsibilities related to complying with data privacy practices. The license holder most recently provided SP1 this training on October 26, 2023;
- the principles of person-centered service planning and delivery as identified in section 245D.07, subdivision 1a, and how they apply to direct support service provided by the staff person. The license holder most recently provided SP1 this training on October 24, 2023;
- the safe and correct use of manual restraint on an emergency basis according to the requirements in section 245D.061 or successor provisions, and what constitutes the use of restraints, time out, and seclusion, including chemical restraint. The license holder most recently provided SP1 this training on October 24, 2023;
- staff responsibilities related to prohibited procedures under section 245D.06, subdivision 5, or successor provisions, why such procedures are not effective for reducing or eliminating symptoms or undesired behavior, and why such procedures are not safe. The license holder most recently provided SP1 this training October 24, 2023; and
- basic first aid.

Corrective Action Ordered: Within 30 days of receiving this order, you must provide SP1 training on the above-mentioned training. On an ongoing basis, you must maintain compliance as required in this subdivision.

If you fail to correct the violations specified in the Correction Order within the prescribed time lines the Commissioner may issue an Order of Conditional License or may impose a fine and order other licensing sanctions pursuant to Minnesota Statutes, sections 245A.06 and 245A.07.

B. Right to Request Reconsideration

If you believe any of the citations are in error, you have the right to request that the Commissioner of Human Services reconsider the parts of the Correction Order that you believe to be in error. The request for reconsideration must be in writing and received by the Commissioner within 20 calendar days after receipt of this report. Your request for reconsideration must be sent to:

Commissioner, Department of Human Services
Office of Inspector General
Legal Counsel's Office
Attention: Licensing Legal Unit
PO Box 64953
St. Paul, MN 55164-0953

Please note that a request for reconsideration does not stay any provisions or requirements of the Correction Order. The Commissioner's disposition of a request for reconsideration is final and not subject to appeal under Minnesota Statutes, chapter 14.

If you have any questions regarding this Correction Order, please contact me as soon as possible.

Nichol Ginther, Human Services Licensor
Licensing Division
Office of Inspector General
651-431-4822