Electronically Delivered

May 5, 2026

Licensee
Aspen Homes
9508 Upton Avenue North
Brooklyn Park, MN 55444

RE: Project Number(s) SL35930015

Dear Licensee:

On November 6, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on July 31, 2024. This follow-up survey verified that the facility is in substantial compliance.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter with your organization's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Casey DeVries, Supervisor
State Evaluation Team
Email: Casey.DeVries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290

HHH

Electronically Delivered

September 6, 2024

Licensee
Aspen Homes
9508 Upton Avenue North
Brooklyn Park, MN 55444

RE: Project Number(s) SL35930015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 31, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. MDH documents state licensing correction orders using federal software. Tag numbers are 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 are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

IMPOSITION OF FINES

In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.31, Subd. 4(a)(5), MDH may impose fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. MDH may impose a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. MDH also may impose a

fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this survey:

St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by MDH within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the

correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. to submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

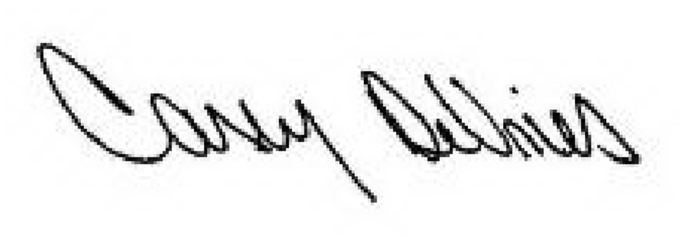
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,



Casey DeVries, Supervisor
State Evaluation Team
Email: Casey.DeVries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35930	A. BUILDING: _____ B. WING _____	07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN HOMES	9508 UPTON AVENUE NORTH BROOKLYN PARK, MN 55444

(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 LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL35930015-0 On July 29, 2024, through July 31, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were five residents, all of whom received services under the Assisted Living license. An immediate correction order was identified on July 29, 2024, issued for SL35930015-0, tag identification 2310. On July 30, 2024, the immediacy of correction order 2310 was removed, however non-compliance remained, and the scope and level remained unchanged.	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.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that:	0 470		

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0 470	Continued From page 1 (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a written staffing plan that included an evaluation completed by the clinical nurse supervisor (CNS) (as indicated in Minnesota Administrative Rule 4659.0180) at least twice a year to determine staffing levels to meet the needs of all residents and failed to ensure the required staffing schedule was posted for residents, staff, and visitors to review as required. This had the potential to affect all residents, staff,	0 470		

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0 470	Continued From page 2 and visitors. 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 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living facility license. The facility was licensed for a bed capacity of six residents and had a current census of five residents. STAFFING PLAN On July 29, 2024, at 11:30 a.m., the surveyor requested the licensee's staffing plan. On July 29, 2024, at 3:42 p.m., LALD/CNS-D stated the employee schedule was what they used as a staffing plan and provided the surveyor with undated document titled [Licensee] Employee Schedule. The schedule contained days of the week, Monday through Sunday, but had no dates and no month indicated. On July 31, 2024, at 12:00 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-D stated the housing manger was supposed to do the staffing plan, and they did not do it. The licensee's undated 4.06 Staffing & Scheduling policy indicated the clinical nurse supervisor, would develop, write, and implement	0 470		

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0 470	Continued From page 3 a staffing plan that would provide sufficient staff to meet the residents needs 24-hours a day, seven-days a week. POSTING On July 29, 2024, at 11:20 a.m., during a facility tour, the evaluator did not observe a posted staff schedule in any area of the facility, developed by the clinical nurse supervisor to: - include direct-care staff work schedules for each direct-care staff member showing all work shifts, including days and hours worked; - identify the direct-care staff member's resident assignments or work location; and - be posted after redacting direct-care staff member's resident assignments, at the beginning of each work shift in a central location. On July 29, 2024, at 11:20 a.m., LALD/CNS-D stated they did not post the staffing schedule anywhere in the facility. They stated the staffing schedules were in the computer, everybody knew their schedule and there was no need to print out and post. Staff did sign in and sign out on papers. The Employee's Time in and out Sheet utilized by the licensee did not include the employee's scheduled work hours. LALD/CNS-D stated they were not aware of the requirement for posting the daily staff schedule. The licensee's undated 4.06 Staffing & Scheduling policy indicated the daily work schedule must be posted, after redacting direct-care staff members' resident assignments, at the beginning of each work shift in a central location in each building of a facility or campus, accessible to staff, residents, volunteers, and the public. The facility shall not disclose any information that is protected by law from public disclosure.	0 470		

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0 470	Continued From page 4 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated July 30, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.	0 480		

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0 480	Continued From page 5 TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance.	0 480		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post the required information related to the grievance procedure and reporting contact information for the Office of Ombudsman for Mental Health and Developmental Disabilities (OMHDD), Office of Ombudsman for Long Term Care Facility (OOLTC), and Office of Health Facility Complaints (OHFC). This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 550		

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0 550	Continued From page 6 safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On July 29, 2024, at 11:25 a.m. during the facility tour, the surveyor observed contact information for Minnesota Adult Abuse Reporting Center posted on a bulletin board in the living room. The surveyor observed the licensee lacked the following postings: - OMHDD; - OOLTC; and - a notice to indicate, if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints (OHFC) at the Minnesota Department of Health. On July 29, 2024, at 11:25 a.m., licensed assisted living director/ clinical nurse supervisor (LALD/CNS)-D stated they had grievance information with the above listed contact information posted on the bulletin board, LALD/CNS-D stated "it might have fell off the wall." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 650 SS=F	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of	0 650		

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0 650	Continued From page 7 each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records included all required content for two of three employees (housing manger/unlicensed personnel (HM/ULP)-A, registered nurse (RN)-C) 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, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic	0 650		

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0 650	Continued From page 8 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: HM/ULP -A HM/ULP-A was hired on July 17, 2020, to provide direct care services to residents. HM/ULP-A's employee record lacked the required documentation for the following training topics: -unplanned times away medication administration. On July 31, 2024, at 10:05 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-D stated ULPs perform unplanned times away medication administration. LALD/CNS-D stated they wrote a policy for how to perform unplanned times away medication administration and had all ULPs review the policy. LALD/CNS-D was unable to provide documentation to show the training was given for any of the ULPs. On July 31, 2024, at 10:11 a.m., HM/ULP-A stated they did prepare medication for residents who were going on unplanned times away. HM/ULP-A stated they put the medications in a zip lock bag with instructions on how take the medications and give them to the resident. HM/ULP-A stated they were trained on how to prepare medication for a resident who was going on unplanned times away by their previous employer and they were also trained by LALD/CNS-D. RN-C RN-C was hired on April 22, 2020, to provide supervision and oversite to unlicensed personnel,	0 650		

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0 650	Continued From page 9 and to provide direct services to residents casually on per diem basis. RN-C's employee record lacked the following: -annual performance review for years 2021, 2022, 2023, and 2024. On July 31, 2024, at 2:05 p.m., LALD/CNS-D stated the annual performance review for RN-C was overlooked. LALD/CNS-D stated "per diem is my weakness, we will hire a part timer next time it is much easier." The licensee's undated 4.05 Employee Records policy read, " PROCEDURE: 1. Employee records for each person will include: " Evidence of current professional licensure, registration or certificate, if required " Records of all training and in-service education required and/or provided including record of competency testing as required " Current signed job description, which includes qualifications, responsibilities, and identification of supervisors, if any " Documentation of annual performance reviews that identify areas of improvement needed and training needs " For individuals providing Assisted Living services, verification that required health screenings for Tuberculosis (TB) have taken place and the dates of those screenings. (recommended to keep medical information in a separate employee medical file) " Documentation of a competed criminal background study " Evidence that a reference check has been completed " Verification of completed orientation and annual training and competency testing as	0 650		

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0 650	Continued From page 10 required." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the	0 680		

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	35930	A. BUILDING: _____ B. WING _____	07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN HOMES	9508 UPTON AVENUE NORTH BROOKLYN PARK, MN 55444

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0 680	Continued From page 11 licensee failed to review the missing resident policy quarterly in accordance with Minnesota Rule Chapter 4659.0110 subp. 4. This had the potential to affect all residents, staff, and visitors. 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 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's Missing Resident Policy dated August 1, 2019. The Missing Resident Policy lacked documentation of quarterly review. On July 31, 2024, at 11:04 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-D stated they did review the missing resident policy quarterly and provided the surveyor with a form entitled Incident Report Log. LALD/CNS-D stated the form was used for elopement, complaint, and resident to resident situation. LALD/CNS-D stated they did quarterly reviews to check if there were any elopements or incidents. The surveyor inquired if they had reviewed the missing resident plan/policy. LALD/CNS-D stated they reviewed all policies quarterly but was not documented, "I do mental documentation". The licensee's Missing Resident Policy dated August 1, 2019, read, " POLICY: When clients are missing, our company staff will conduct a thorough search to locate the client.	0 680		

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0 680	Continued From page 12 PROCEDURE: In the event a client has disappeared the following will happen: 1. The person that first notices a client missing will alert co-workers that a client is missing. Include: name, apartment number, description, and where last seen. 2. Immediately search inside the building for the client. 3. Call family to ask them if they have forgotten to sign the client out. 4. If client is not found notify Housing Manager. 5. Housing Manager will then assign employees to search outside the facility, covering all grounds in front of or behind building. 6. If client is still not found, notify 911. Have the following information available: o Name of client o Description of client including what the client was wearing o Time when client was last seen 7. Update family of steps taken to locate client. 8. When client is found make sure to complete an incident report including all information concerning disappearance. Including the following: o Time of first alert concerning client disappearance o Procedure taken, staff involved o Time of notification of 911 and family, if involved o Time when found 9. Determine if alternate approaches to minimize the future risk of elopement are to be implemented." Per Assisted Living Facilities: Minnesota Rules Chapter 4659, 4659.0110, Subp. 4. Review missing resident plan. The assisted living director and clinical nurse supervisor must review the missing person plan at least quarterly and	0 680		

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0 680	Continued From page 13 document any changes to the plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee	0 780		

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0 780	Continued From page 14 failed to provide smoke alarms that functioned and were interconnected so that the actuation of one alarm caused all alarms in the dwelling unit to actuate. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause 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 portion or all of the residents). The findings include: On July 30, 2024, from approximately 11:05 a.m. to 11:45 a.m., survey staff toured the facility with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-D. Survey staff tested the smoke alarms throughout the home. Upon testing, the smoke alarms in the following locations did not sound when the test button was pressed: 1. Bedroom 2 smoke alarm had no battery. 2. Bedroom 3 smoke alarm was not working. 3. The smoke alarms were not interconnected throughout the facility. These deficient conditions were visually verified by LALD/CNS-D accompanying on the tour. On July 30, 2024, at 11:30 a.m., LALD/CNS-D stated they had installed new smoke alarms, but they did not know why the above-listed locations were not working and had the battery removed. LALD/CNS-D stated they understood the smoke	0 780		

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0 780	Continued From page 15 alarm requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the portable fire extinguishers. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	0 790		

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0 790	Continued From page 16 The findings include: On July 30, 2024, from approximately 11:05 a.m. to 11:45 a.m., survey staff toured the facility with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-D. The portable fire extinguishers throughout the facility were not the correct classification size. On July 30, 2024, at 11:30 a.m., survey staff explained to LALD/CNS-D that the portable fire extinguishers that they were currently using were rated 1-A:10BC and should be rated 2-A:10BC. LALD/CNS-D stated they understood the requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings,	0 800		

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0 800	Continued From page 17 grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the potential to affect all staff, residents, and visitors. 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 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On July 30, 2024, from approximately 11:05 a.m. to 11:45 a.m., survey staff toured the facility with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-D. The following was observed. GENERAL MAINTENANCE: The carpet was stained and soiled on the staircase that leads to the upstairs/downstairs. Downstairs family room had carpet stains and bedrooms #1 and #5 also had stains in the carpet. Bedroom # 3 bathroom had the vanity door falling off. The laundry closet door was broken and falling off its track. The basement bathroom ventilation fan was not working and the finish on the vanity was peeling	0 800		

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0 800	Continued From page 18 off. There was also a hole in the wall behind the bathroom door. The vinyl flooring in the upstairs hallway was coming up. Paint was coming off the staircase railing and throughout the walls in the house. On July 30, 2024, at 11:30 a.m., LALD/CNS-D stated they understood the above-listed deficiencies. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility.	0 810		

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0 810	Continued From page 19 (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On July 30, 2024, licensed assisted living director/ clinical nurse supervisor (LALD/CNS)-D provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility.	0 810		

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0 810	Continued From page 20 FIRE SAFETY AND EVACUATION PLAN: The FSEP (fire safety and evacuation plan) included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate) but the plan was designed for a building with life safety systems such as fire doors with magnetic holders and smoke compartments. The policy had not been updated to provide complete actions for employees to take in the event of a fire or similar emergency at the licensed facility which did not have life safety systems or a fire-resistant construction type. Evacuation emergency exit map did not identify location and and number of resident rooms. TRAINING: The licensee failed to provide evacuation training to residents at least once per year. LALD/CNS-D did not have this documentation. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
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 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	01060		

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01060	Continued From page 21 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 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	01060		

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01060	Continued From page 22 required content for an emergency relocation for one of one resident (R3). 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: R3's diagnosis included hypertension, depression, and anxiety. R3's signed service plan, dated March 29, 2023, indicated R3 received assistance with medication administration, dressing, hygiene/grooming, housekeeping and linen change, laundry, and food preparation. R3 was hospitalized on June16, 2024, and returned on June 19, 2024. R3's record lacked evidence a written notice was provided to R3 that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the Office of Ombudsman for Long-Term Care; - 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 - a statement that, if the facility refuses to provide	01060		

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01060	Continued From page 23 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. On July 30, 2024, at 1:30 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-D, stated they were not aware of the requirement to provide a written notice with required contents for an emergency relocation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01290 SS=D	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the	01290		

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01290	Continued From page 24 licensee failed to ensure a background study (BGS) was submitted and received in affiliation with the assisted living license for one of seven employees (unlicensed personnel (ULP)-E). 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: ULP- E was hired on April 11, 2020, to provide direct cares and services to residents. ULP-E's employee record included a letter from the Department of Human Services dated June 20, 2024, which indicated the employee's background study fingerprints and photo were not provided in the time required- the entity must immediately remove the employee from their position. The licensee's NETstudy 2.0 roster did not include ULP-E's BGS. The licensee's sister facility under HFID 34457 NETstudy 2.0 roster indicated ULP-E was eligible. The licensee lacked evidence ULP-E was affiliated to the licensee's HFID 35930 and was not included on the NETstudy 2.0 roster provided by the licensee. On July 31, 2024, at 10:32 a.m., licensed assisted living director (LALD/CNS)-D stated they were not aware ULP-E did not have a cleared BGS for the licensee. LALD/CNS-D stated ULP-E	01290		

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01290	Continued From page 25 had a cleared BGS with their homecare company and that was what they used for the licensee's facility. LALD/CNS-D also stated they submitted a BGS for ULP-E yesterday (July 30, 2024). Surveyor requested to see the BGS application, which was never provided by the licensee. The licensee's undated 4.02 Background Studies read, " POLICY: [Name of AL] will conduct a Minnesota Department of Human Services Background Study on all employees and volunteers and contractors at [Name of AL]. No employee may provide direct services and have independent direct contact with any residents until acceptable result of the background study have been received. [Name of AL] will not employ individuals whose results of the background study indicate disqualification for the position." No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the	01500		

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01500	Continued From page 26 exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology	01500		

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01500	Continued From page 27 that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an employee received at least eight hours of annual training for each 12 months of employment for one of three employees (registered nurse (RN)-C). 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: RN-C was hired on April 22, 2020, to provide supervision and oversite to unlicensed personnel, and to provide direct services to residents. RN-C's employee record lacked eight hours of annual training completed within the last 12 months to include: - reporting maltreatment of vulnerable adults; - assisted living bill rights; - infection control techniques; - effective approaches to use to problems solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's	01500		

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01500	Continued From page 28 disease, or related disorders; - review of provider policies and procedures; and - principles of person-centered planning/service delivery. On July 30, 2024, at approximately 2:15 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-D stated the annual and the dementia training for RN-C was overlooked as RN-C worked for the licensee casually, only once or twice a year. The licensee's undated 5.06 Annual Required Staff Training policy, read, "The following training elements MUST be included every 12 months to all staff who performs direct care services: 1. Training on reporting of maltreatment of vulnerable adults under section 626.557 2. Review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights 3. Review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases 4. Effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders 5. Review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures	01500		

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01500	Continued From page 29 6. Principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
01820 SS=F	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain current medication orders for four of four residents (R2, R3, R4 and R5) 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, but was not likely to cause 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 portion or all of the residents). The findings include: R2 R2's diagnoses included diabetes mellitus, depression, schizophrenia, anxiety, and paranoid.	01820		

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01820	Continued From page 30 R2's Service Plan dated March 29, 2023, indicated R2 received services for, dressing, medication assistance, oral care, nail care, and meal reminders. R2's record included physician order dated October 5, 2022. R2's record lacked evidence to show the physician order was updated annually in 2023. R2's medication administration record (MAR) dated July 1, 2024, through July 31, 2024, indicated R2 received the following medications: fluoxetine 10 milligram (mg) capsule (cap), metformin 100mg, tablet (tab), buspirone 15mg tab, naltrexone 15mg tab, vitamin D3 1000unit cap, lovastatin 40mg tab, and risperidone 2mg tab. R3 R3's diagnoses included diabetes hypertension, heartburn, and depression. R3's Service Plan dated March 29, 2023, indicated R3 received services for, bathing assistance, personal laundry, dressing, medication assistance, oral care, and meal reminders. R3's record included physician order dated March 29, 2023. R3's record lacked evidence to show the physician order was updated annually in March 2024, with the current medication orders. R3's medication administration record (MAR) dated July 1, 2024, through July 31, 2024, indicated R3 received the following medications: amlodipine 5mg tab, lamotrigine 25mg tab, tab-A-vite 1 tab, prazosin HCL 2mg cap,	01820		

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01820	Continued From page 31 acetaminophen 325mg tab, famotidine 40mg tab, quetiapine fumarate 25mg tab, tizanidine 2mg tab, clobetasol 0.05% ointment, and vanicream. R4 R4's diagnoses included diabetes, hypertension, schizophrenia, and depression. R4's Service Plan dated October 6, 2020, indicated R4 received services for, bathing assistance, feeding, hygiene/grooming, personal laundry, dressing, medication assistance, and housekeeping. R4's record included physician order dated January 10, 2023. R4's record lacked evidence to show physician order was updated with the current medication orders annually which was due in January 2024. R4's medication administration record (MAR) dated July 1, 2024, through July 31, 2024, indicated R4 received the following medications: aspirin 81milligram (mg) tablet (tab), atorvastatin 40mg tab, sertraline 100mg tab, vitamin B-12 1000micrograms (mcg) tab, metformin 500mg tab, olanzapine 5mg tab, trazodone 50mg tab, and terbinafine 250mg. R5 R5's diagnoses included diabetes, hypertension, schizophrenia, and depression. R5's Service Plan dated March 4, 2020, indicated R5 received services for, bathing assistance, feeding, hygiene/grooming, personal laundry, dressing, medication assistance, and housekeeping. R5's record included physician order dated May	01820		

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01820	Continued From page 32 1, 2023. R5's record lacked evidence to show physician order was updated with the current medication orders annually which was due in May 2024. R5's medication administration record (MAR) dated July 1, 2024, through July 31, 2024, indicated R5 received the following medications: aripiprazole 20mg tab, aspirin 81mg tab, divalproex 250mg tab, lisinopril 5mg tab, omeprazole, 20mg cap, Thera-M- Enhanced tab, vitamin D3 1000 unit cap, metformin 500mg tab, propranolol 20mg tab, atorvastatin 20mg ta, divalproex 500mg tab, haloperidol 10mg tab, senna 8.6mg tab, zolpidem 5mg tab and haloperidol 100mg/milliliter (ml) 1ml injection. On July 31, 2024, at 10:40 a.m., licensed assisted living director/ clinical nurse supervisor (LALD/CNS)-D stated they had sent out a renewal form to the physicians for all residents and it never came back. The licensee was unable to produce evidence to show they had sent a renewal form to the physicians for any of the residents mentioned above. The licensee's undated Medication Management Services Required Policy read, " An assisted living facility that provides medication management services must develop, implement, and maintain current written medication management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse, licensed health professional, or pharmacist consistent with current practice standards and guidelines." No further information was provided.	01820		

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01820	Continued From page 33 TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide documentation of disposition of medications for one of one discharged resident (R6). 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	01910		

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01910	Continued From page 34 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: The licensee's undated Discharged or Deceased Resident Roster indicated R6 was admitted to the licensee on May 24, 2020, and discharged on February 28, 2023. R6's signed service plan dated May 31, 2020, indicated R6 received the following services: medication administration and storage, bathing assistance, hygiene/grooming, dressing, personal laundry, and assistance with mobility. R6's medication administration record dated February 1 to February 28, 2023, indicated R6 took the following medications: propranolol 10 milligram (mg) tablet (tab), melatonin 3mg tab, mirtazapine 15mg tab, trazodone 50mg tab, acetaminophen 500mg tab, gabapentin 100mg, ibuprofen 800mg tab, aspirin 81mg tab, atorvastatin 20mg tab, lisinopril 10mg tab, oxybutynin 5mg tab, vitamin D3 5,000unit tab, gemfibrozil 600mg tab, and amantadine 100mg capsule (cap). R6's record lacked evidence of documented disposition of medications for R6 to include: the name of the medication, strength, prescription number if applicable, quantity, to whom the medications were given, date of disposition, and the names of the staff and other individuals involved in the disposition. On July 31, 2024, at 9:30 a.m., the surveyor requested medication disposition form for R6.	01910		

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01910	Continued From page 35 Licensed assisted living director/clinical nurse supervisor (LALD/CNS)-D stated they did not utilize medication disposition form for non-narcotic medications. LALD/CNS-D stated "we do not count pills and write them down we just put it in a plastic bag along with their physician order and the MAR [medication administration record] and give it to them." Licensee's Assisted Living License Rescource Manual - 1.21 policy titled [Name of AL] Resident Discharge Summary sample form indicated the licensee would provide a reconciliation of a pre-dischared medications with the resident's post-discharge prescribed and over-the-counter medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for one of one resident (R1) with hospital bed rails. This resulted in an immediate correction order on July 29,	02310		

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02310	Continued From page 36 2024. 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 portion or all of the residents). The findings include: On July 29, 2024, at approximately 11:35 a.m., during a facility tour the surveyor observed an upper half bed rail on the left side of R1's hospital bed. Licensed assisted living director/clinical nurse supervisor (LALD/CNS)-D stated they had not seen the bed rail or the hospital bed before this date. LALD/CNS-D stated they were not aware R1 had hospital bed with a bedrail. R1 stated the bedrail came with the bed about a couple weeks or a month ago. R1's diagnoses included neuropathy, congestive heart failure, hypertension, and diabetes. R1's Tasks Assigned/Plan of Care dated April 22, 2022, indicated R1 received services for assisting with dressing- lower extremities, biweekly laundry, weekly housekeeping, daily room order, meal reminder, and transfer assist to get in and out of bed. R1's record lacked the following: -bedrail assessment with entrapment zone measurement; -benefits and risks of bed rails use; and -evidence the bed rail has not shifted and is	02310		

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02310	Continued From page 37 securely attached to the bed frame per manufacturer recommendations. On July 29, 2024, at approximately 1:30 p.m., LALD/CNS-D provided a side rail assessment entitled Side-Rail Use Assessment Form dated July 2, 2024, and stated the other nurse (registered nurse (RN)-C) completed the form and they were not aware. The form also contained R1's signature. On July 29, 2024, at approximately 1:45 p.m., LALD/CNS-D stated they did not have the manufacturer's instructions for R1's bed rail. On July 29, 2024, at approximately 2:00 p.m., during an interview R1 stated the document was brought to them by LALD/CNS-D. R1 stated the document "might" have been signed today, but R1 did not want to fully disclose the information. On July 29, 2024, at approximately 2:30 p.m., LALD/CNS-D denied having provided the assessment to R1 to sign today. On July 29, 2024, at approximately 3:40 p.m., LALD/CNS-D stated they were aware of the required contents to be included in a bed rail assessment and confirmed that the bed rail assessment they provided for R1 did not contain the required elements. The Food and Drug Administration's (FDA), A Guide to Bed Safety, dated 2000, and revised April 2010, indicated following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain,	02310		

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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
02310	Continued From page 38 uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The March 10, 2006, FDA Side Rail Entrapment Zones and Dimensional Recommendations indicated to reduce the risk of entrapment, zone 1 (within the rail) should not exceed 4 and 3/4 inches, zone 2 (under the rail, between rail supports or next to a single rail support) should not exceed 4 and 3/4 inches, zone 3 (between the rail and the mattress), should not exceed 4 and 3/4 inches, and zone 4 (under the rail, at the ends of the rail) should not exceed 2 and 3/8 inches or be greater than a 60 degree angle. The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently Asked Questions (FAQs) indicated the need for assistive devices, such as bed rails, must be assessed upon initial installation, with each 90-day assessment and change of condition. (Please refer to Rule 4659.0150 where it directs assessment of mobility, including ambulation, transfers, and assistive devices.) The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35930	A. BUILDING: _____ B. WING _____	07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN HOMES	9508 UPTON AVENUE NORTH BROOKLYN PARK, MN 55444

(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
02310	Continued From page 39 movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, documentation about a resident's hospital bed rail should include, but is not limited to: Purpose and intention of the bed rail Measurements The resident's bed rail use/need assessment Risk vs. benefits discussion (individualized to each resident's risks) The resident's preferences Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements. The licensee's 6.28 Side Rails Policy dated August 1, 2021, read, " POLICY: When [name of licensee] is aware a home care resident is utilizing side rails (a medical device) on a bed, [Name of AL] will assess the use, educate the resident, and when appropriate, the responsible person, regarding the risks and benefits of side rails, and verify that the side rail in use is of a safe design and utilized consistent with the manufacturer's directions. This policy shall be followed regardless of who owns or is supplying the side rail." TIME PERIOD FOR CORRECTION: Immediate On July 30, 2024, the immediacy of correction order 2310 was removed, however non-compliance remained, and the scope and level remained unchanged.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35930	A. BUILDING: _____ B. WING _____	07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN HOMES	9508 UPTON AVENUE NORTH BROOKLYN PARK, MN 55444

(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
03090	Continued From page 40	03090		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the required notice was posted at the main entryway of the facility to display statutory language to disclose electronic monitoring activity. This had the potential to affect all of the licensee's residents, staff, and visitors. This practice resulted in a level one violation (a violation that has not potential to cause more than a minimal impact on the resident and does not affect health or safety) 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 portion or all the residents). The finding include: On July 29, 2024, at 10:10 a.m., the surveyor observed a signage posted at the main entrance indicating the area is under 24 hours video surveillance. The signage did not include a statement to indicate electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities.	03090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35930	A. BUILDING: _____ B. WING _____	07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN HOMES	9508 UPTON AVENUE NORTH BROOKLYN PARK, MN 55444

(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
03090	Continued From page 41 On July 29, 2024, at 11:35 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-D stated they were not aware the signage was supposed to include a statement to indicate electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090		

Minnesota Department of Health
Food, Pools, & Lodging Services
P.O. Box 64975
Saint Paul, MN 55164-0975
651-201-4500

Type: Follow-Up
Date: *08/20/24*
Time: 09:52:03
Report: 1021241231

Food and Beverage Establishment Inspection Report

Location:
Aspen Homes
9508 Upton Avenue North
Brooklyn Park, MN55444
Hennepin County, 27

Establishment Info:
ID #: 0039157
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 6128761913
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

No NEW orders were issued during this inspection.

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	0	0	0

TODAY'S FOLLOW UP WAS TO ADDRESS AND CLEAR PREVIOUSLY WRITTEN ORDERS FROM A FULL INSPECTION CONDUCTED ON 07/30/24. 11 OUT OF 11 ORDERS WERE CLEARED FROM THE REPORT.

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 1021241231 of 08/20/24.

Certified Food Protection Manager: HUSEN S. ROBLEH

Certification Number: FM93538 Expires: 08/09/27

Inspection report reviewed with person in charge and emailed.

Signed: _____
FATHIA MOUSSA
DIRECTOR/RN

Signed: _____
Melissa Ramos
Environmental Health Specialist
Metro District Office
651-201-4495
Melissa.Ramos@state.mn.us

Minnesota Department of Health
Food, Pools, & Lodging Services
P.O. Box 64975
Saint Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *07/30/24*
Time: 11:36:07
Report: 1021241207

Food and Beverage Establishment Inspection Report

Location:
Aspen Homes
9508 Upton Avenue North
Brooklyn Park, MN55444
Hennepin County, 27

Establishment Info:
ID #: 0039157
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 6128761913
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

The following orders were issued during this inspection.

2-200 Employee Health

2-201.11C ***** Priority 1 *****

MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority.

NO EMPLOYEE ILLNESS LOG ON-SITE. DISCUSSED EMPLOYEE ILLNESS POLICY AND RECORDING WITH DIRECTOR. AN MDH EMPLOYEE ILLNESS LOG SENT WITH REPORT.

Comply By: 07/31/24

3-300B Protection from Contamination: cross-contamination, eggs

3-302.11A(1) ***** Priority 1 *****

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

A CARTON OF RAW SHELL EGGS WAS FOUND STORED ABOVE GRAPES AND OTHER VEGETABLES IN THE WHIRLPOOL REFRIGERATOR. THE CARTON OF RAW SHELL EGGS WAS MOVED TO THE BOTTOM SHELF TO PREVENT ANY CROSS CONTAMINATION. CORRECTED ON-SITE.

Comply By: 07/30/24

4-300 Equipment Numbers and Capacities

4-302.13B ***** Priority 2 *****

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

ESTABLISHMENT DOES NOT HAVE A MEASURING DEVICE THAT INDICATES THE FINAL UTENSIL SURFACE TEMPERATURE IN DISH MACHINE. PER CONVERSATION WITH STAFF,

THEY RAN OUT OF THE THERMOLABELS. ONE THERMOLABEL LEFT ON-SITE TODAY. SEE COMMENTS.
Comply By: 07/30/24

4-300 Equipment Numbers and Capacities

4-302.14 ***** Priority 2 *****

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.
NO TEST KIT ON-SITE TO MEASURE THE CONCENTRATION OF BLEACH. PROVIDE.
Comply By: 08/06/24

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.
THE CERTIFIED FOOD PROTECTION MANAGER CERTIFICATE (CFPM) FOR HUSEN ROBLEH EXPIRED 04/11/2024. INFORMATION ON HOW TO RENEW CFPM CERTIFICATE SENT WITH REPORT.
Comply By: 08/30/24

4-200 Equipment Design and Construction

4-204.112A

MN Rule 4626.0620A Provide a temperature measuring device located in the warmest part of mechanically refrigerated units and coolest part of hot food storage units that are capable of measuring air temperature or a simulated product temperature.
NO MEASURING DEVICE IN THE WHIRLPOOL REFRIGERATOR. PLACE A THERMOMETER IN THE WARMEST PART OF THE REFRIGERATOR AS DESCRIBED IN RULE ABOVE.
Comply By: 08/06/24

4-300 Equipment Numbers and Capacities

4-303.11B

MN Rule 4626.0721B Provide chemical sanitizers to sanitize equipment and utensils during all hours of operation.
NO SANITIZER ON-SITE THAT IS APPROVED WITH FOOD CONTACT SURFACES. PER CONVERSATION WITH STAFF, THEY JUST RAN OUT OF BLEACH. STAFF IS GOING TO GET BLEACH TODAY. APPROVED SANITIZER FACT SHEET SENT WITH REPORT. COMPLY WITH RULE ABOVE.
Comply By: 07/30/24

4-500 Equipment Maintenance and Operation

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.
THE FOOD THERMOMETER DOES NOT TURN ON. STAFF IS GOING TO GET NEW BATTERIES. MAKE SURE FOOD THERMOMETER IS WORKING.
Comply By: 08/04/24

4-600 Cleaning Equipment and Utensils

4-601.11C

MN Rule 4626.0840C Clean non-food contact surfaces of equipment and maintain free of accumulations of dust, dirt, food residue, and other debris.

BOTTOM PART OF THE MICROWAVE AND THE VENTILATION FILTER UNDER THE MICROWAVE CONTAINS ACCUMULATION OF GREASE. CLEAN AND MAINTAIN CLEAN.

Comply By: 08/04/24

6-300 Physical Facility Numbers and Capacities

6-301.14A

MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands

HANDWASHING SINKS IN THE KITCHEN AND IN THE BASEMENT BATHROOM ARE MISSING A HANDWASHING SIGN/POSTER THAT REMINDS FOOD EMPLOYEES TO WASH THEIR HANDS BEFORE RETURNING TO WORK. PROVIDE AS DESCRIBED IN RULE ABOVE.

Comply By: 08/01/24

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.12A

MN Rule 4626.1520A Clean and maintain all physical facilities clean.

CEILING ABOVE THE STOVE CONTAINS A SMOKE STAIN AND POSSIBLY GREASE. CLEAN CEILING AND MAINTAIN CLEAN.

Comply By: 08/30/24

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: MILK - WHIRLPOOL REFRIGERATOR
Violation Issued: No

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: SLICED HAM - WHIRLPOOL REFRIGERATOR
Violation Issued: No

Process/Item: Ambient Temperature
Temperature: 39 Degrees Fahrenheit - Location: WHIRLPOOL REFRIGERATOR
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	2	2	7

ALL FINDINGS ON THIS REPORT WERE DISCUSSED WITH DIRECTOR, FATHIA MOUSSA AND HEALTH REGULATION DIVISION NURSE EVALUATOR, DEE MOSISSA.

THIS FACILITY IS A RESIDENTIAL HOME AND THEY CURRENTLY HAVE 5 CLIENTS AND THE FACILITY CAN HAVE UP TO 6 CLIENTS.

PER CONVERSATION WITH DIRECTOR, FOOD IS MADE FOR SAME DAY SERVICE. NO

LEFTOVERS ARE KEPT.

THE KITCHEN HAS RESIDENTIAL EQUIPMENT, POPCORN CEILING, AND LAMINATE COUNTERTOPS. PHYSICAL FACILITY ITEMS WILL BE MONITORED DURING FUTURE INSPECTIONS.

CONTINUATION OF MN Rule 4626.0710B
STAFF ARE GOING TO RUN THE DISH MACHINE AND THEY ARE GOING SEND A PICTURE OF THE THERMOLABEL TO INSPECTOR TO MAKE SURE THE DISH MACHINE IS REACHING A FINAL UTENSIL SURFACE TEMPERATURE OF AT LEAST 160F.

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 1021241207 of 07/30/24.

Certified Food Protection Manager: HUSEN SALAH ROBLEH

Certification Number: FM93538 Expires: 04/11/24

Inspection report reviewed with person in charge and emailed.

Signed: _____
FATHIA MOUSSA
DIRECTOR/RN

Signed: _____
Melissa Ramos
Environmental Health Specialist
Metro District Office
651-201-4495
Melissa.Ramos@state.mn.us