Electronically Delivered

February 12, 2025

Licensee
Loving Residence LLC
1760 Perlich Avenue
Red Wing, MN 55066

RE: Project Number(s) SL30421016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 7, 2025, 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.

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

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 . . ."

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

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

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,

Jodi Johnson, Supervisor
State Evaluation Team
Email: Jodi.Johnson@state.mn.us
Telephone: 507-344-2730 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
	30421	A. BUILDING: _____ B. WING _____	01/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOVING RESIDENCE LLC	1760 PERLICH AVENUE RED WING, MN 55066

(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 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: SL30421016-0 On January 6, 2025, through January 7, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 10 residents; 10 receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	

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0 630	Continued From page 1	0 630		
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for one of two residents (R2). 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: R2 was admitted on October 29, 2019, with diagnoses that included stroke. R2's service plan dated February 27, 2023,	0 630		

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0 630	Continued From page 2 indicated R2 received assistance with blood glucose checks, compression socks, dressing, grooming, bathing/shower, and continence care. On January 6, 2025, at 11:56 a.m., the surveyor observed unlicensed personnel (ULP)-D administer medications to R2. R2's IAPP dated November 12, 2024, did not include the following required items: - the resident's susceptibility to abuse by another individual, including other vulnerable adults - statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. On January 7, 2025, at 8:15 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A reviewed R2's IAPP and stated it did not include the required content as listed above. The licensee's Individual Abuse Prevention Plan policy dated May 23, 2023, indicated the licensee would implement and IAPP for each vulnerable adult. The plan would contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including: a. Other vulnerable adults b. The person's risk of abusing other vulnerable adults, and c. Statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		

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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) staff 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) Staff 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. (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 staff 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	0 810		

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0 810	Continued From page 4 safety and evacuation plan with required content, make the plan readily available, and provide required training and documentation. 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 January 6, 2025, at 11:30 p.m., maintenance director (MD)-C provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. The licensee FSEP failed to include the following: The FSEP did not include a map of lower level of facility and failed to include room numbers for resident sleeping rooms throughout the facility. The FSEP did not include appropriate employee actions to during a fire or similar emergency. The minimal include verbiage referenced "loudspeaker" announcements and that staff should "pull fire alarm" station, which are not applicable to this facility. MD-C indicated that there were not employee actions for evacuation specific to the facility, and that much of the language had been borrowed from another facility with specific information relevant to that other facility.	0 810		

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0 810	Continued From page 5 FSEP did not include fire procedures for residents that were appropriate for facility. Resident plans were not sufficient, and the limited actions included information not applicable to the facility such as activation of a "pull station" located in a specific location, which was not accurate for this facility. FSEP did not include sufficient records of employee training and MD-C indicated that staff training occurs once per year. Training on the FSEP is required upon hire and twice per year thereafter for all employees. During the record review and interview on January 6, 2025, MD-C verified the above listed documents were absent from the FSEP. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the	0 970		

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0 970	Continued From page 6 licensee's liability for health, safety, or personal property of a resident. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no 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 of the residents). The findings include: The licensee's Assisted Living Contract included a clause that indicated the resident would waive the licensee's liability for health, safety, or personal property of a resident. -Page 14 of the agreement indicated: "Indemnification: as an occupant of the community, resident assumes the risk for resident's own safety and for the safety of resident's guest and agents. Resident will indemnify and hold harmless provider, its employees, officers, managers, owners, and agents from and against an and all claims, actions, damages, and liability and expense in connection with loss of life, personal injury, or damage to property, arising from or out of, or caused wholly or in part by, an act or omission of resident or resident's guest or agents. On January 7, 2025, at 8:26 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee's contract included the above content, and further stated the same contract was utilized for all residents at the facility.	0 970		

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0 970	Continued From page 7 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a written service plan was revised to reflect the current services provided for one of two residents (R1). This practice resulted in a level two violation (a	01640		

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01640	Continued From page 8 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: R2 was admitted on October 29, 2019, with diagnoses that included stroke. On January 6, 2025, at 11:56 a.m., the surveyor observed unlicensed personnel (ULP)-D administer medications to R2. R2's service plan dated February 27, 2023, indicated R2 received assistance with blood glucose checks, compression socks, dressing, grooming, bathing/shower, and continence care. R2's service plan did not include medication administration or medication setup. R2's Medication Administration Record (MAR) dated January 2025, indicated R2 received medication administration five times a day. R2's Med Setup/Review Summary dated January 2025, indicated the nurse set up R2's medications weekly. On January 7, 2025, at 8:17 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated R2's service plan did not include medication management services to include medication administration and medication setup.	01640		

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01640	Continued From page 9 The licensee's Service Plan policy dated May 22, 2023, indicated the service plan would include a description of the services that are to be provided based on the most recent assessment and resident preferences. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		

Minnesota Department of Health
Food, Pools, Lodging
3425 40th Ave NW
Rochester
507-206-2721

Type: Full
Date: *01/06/25*
Time: 10:06:32
Report: 8074251001

Food and Beverage Establishment Inspection Report

Location:
Loving Residence Llc
1760 Perlich Avenue
Red Wing, MN55066
Goodhue County, 25

Establishment Info:
ID #: 0037895
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6513881650
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.

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 of freezer has food debris, silverware drawer has food debris.

Comply By: 01/13/25

6-100 Physical Facility Construction Materials

6-101.11A1

MN Rule 4626.1325A1 Provide smooth, durable, and easily cleanable floor, wall and ceiling surfaces.

Carpet beneath freezers in basement, unfinished sheetrock.

Comply By: 01/06/26

Food and Equipment Temperatures

Process/Item: Upright Cooler
Temperature: 49 Degrees Fahrenheit - Location: tune salad cooling 1 hr from ambient
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 40 Degrees Fahrenheit - Location: jello
Violation Issued: No

Type: Full
Date: *01/06/25*
Time: 10:06:32
Report: 8074251001
Loving Residence Llc

Food and Beverage Establishment Inspection Report

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

Dish machine sticker 160df.

Establishment Info:
andrea@valentinesllc.com

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 8074251001 of 01/06/25.

Certified Food Protection Manager: Jessica E. Johnson

Certification Number: FM89801 Expires: 07/07/26

Inspection report reviewed with person in charge and emailed.

Signed: _____
Establishment Representative

Signed: _____
Andrea Kieffer

Rochester District Office