Electronically Delivered

December 11, 2023

Licensee
Unified Health Care
6940 Zane Avenue North
Brooklyn Park, MN 55429

RE: Project Number(s) SL38864015

Dear Licensee:

This is your **official notice** that you have been **granted your assisted living facility license with dementia care.** Your license effective and expiration dates remain the same as on your provisional license. Your updated status will be listed on the license certificate at renewal and **this letter serves as proof** in the meantime. If you have not received a letter from us with information regarding renewing your license within 60 days prior to your expiration date, please contact us at (651) 201-5273 or by email at Health.assistedliving@state.mn.us.

The Minnesota Department of Health completed an initial survey on November 10, 2023, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

STATE CORRECTION ORDERS
The enclosed State Form documents the state correction orders. The Department of Health documents state correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Home Care 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 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
Per 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 residents/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 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 the Department of Health within 15 calendar days of the correction order receipt date.

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and/or 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

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38864	A. BUILDING: _____ B. WING _____	11/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIFIED HEALTH CARE	6940 ZANE AVENUE NORTH BROOKLYN PARK, MN 55429

(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: SL38864015-0 On November 6, 2023, through November 8, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were five (5) active residents receiving services under the Provisional Assisted Living with Dementia Care 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 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.	
0 650 SS=F	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled	0 650		

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0 650	Continued From page 1 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 interview and record review, the licensee failed to ensure employee records contained documentation of training and competency evaluations to include authentication of the trainer who has delegated tasks to unlicensed personnel (ULP) congruent with requirements of 144G.62, Subdivisions 2 through 4., for two of two employees (ULP-B, 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	0 650		

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0 650	Continued From page 2 or has the potential to affect a large portion or all of the residents). The findings include: On November 6, 2023, at 11:30 a.m., clinical nurse supervisor (CNS)-A stated all ULPs received classroom training, competency, and completed return demonstration with a registered nurse (RN) before starting to work with residents. ULP-B ULP-B started employment with licensee June 29, 2023. On November 7, 2023, from 7:30 a.m., through 8:16 a.m., the surveyor observed ULP-B complete medication administration for licensee's residents. On November 7, 2023, at 9:23 a.m., ULP-B stated he completed classroom training and competency and completed return demonstration with a RN before he started working on the floor (with residents). ULP-B's record contained training document titled, Training of Unlicensed Personnel Only, unsigned, and undated indicated ULP-B had completed all required training and competency in 22 areas with a check mark against each topic: (1) documentation requirements for all services provided; (2) reports of changes in the client's condition to the supervisor designated by the home care provider; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal	0 650		

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0 650	Continued From page 3 hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; (iv) dressing and assisting with toileting; (6) training on the prevention of falls for providers working with the elderly or individuals at risk of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the client and showing respect for the client and the client's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and clients and the client's family; (14) procedures to utilize in handling various emergency situations; (15) awareness of commonly used health technology equipment and assistive devices; (16) observation, reporting, and documenting of client status; (17) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (18) reading and recording temperature, pulse, and respirations of the client; (19) recognizing physical, emotional, cognitive, and developmental needs of the client; (20) safe transfer techniques and ambulation; (21) range of motioning and positioning;	0 650		

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0 650	Continued From page 4 (22) administering medications or treatments as required; and (d) Other RN/professionally delegated tasks (i.e., monitor vital signs, catheter or stoma care, Broda chair, mechanical lifts). ULP-E ULP-E started employment with licensee March 22, 2023. On November 7, 2023, at 8:05 a.m., the surveyor observed ULP-E prepare coffee and serve residents breakfast in the dining room. ULP-E's record contained training document titled, Training of Unlicensed Personnel Only, unsigned, and undated indicated ULP-E had completed all required training and competency in 22 areas with a check mark against each topic: (1) documentation requirements for all services provided; (2) reports of changes in the client's condition to the supervisor designated by the home care provider; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; (iv) dressing and assisting with toileting; (6) training on the prevention of falls for providers working with the elderly or individuals at risk of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment	0 650		

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0 650	Continued From page 5 reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the client and showing respect for the client and the client's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and clients and the client's family; (14) procedures to utilize in handling various emergency situations; (15) awareness of commonly used health technology equipment and assistive devices; (16) observation, reporting, and documenting of client status; (17) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (18) reading and recording temperature, pulse, and respirations of the client; (19) recognizing physical, emotional, cognitive, and developmental needs of the client; (20) safe transfer techniques and ambulation; (21) range of motioning and positioning; (22) administering medications or treatments as required; and (d) Other RN/professionally delegated tasks (i.e., monitor vital signs, catheter or stoma care, Broda chair, mechanical lifts). On November 7, 2023, at 11:55 a.m., operation director (OD)-D stated ULP-B and ULP-E had completed all required training and competency. However, ULP-B, ULP-E, and all other ULP records had not been signed or dated by RN and ULP upon completion of training.	0 650		

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0 650	Continued From page 6 The licensee's undated Competency Evaluations policy indicated the licensee shall implement and provide a competency evaluation program that meets the minimum standards in accordance with state guidelines. The policy lacked verbiage to include if the records are signed and dated when completed. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on	0 660		

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0 660	Continued From page 7 the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included baseline testing and screening for two of two employees (unlicensed personnel (ULP)-B, 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) 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: The licensee's TB facility risk assessment tool dated July 11, 2023, indicated the licensee was a medium risk for TB. ULP-B ULP-B started employment with licensee June 29, 2023. ULP-B's TB Testing Documentation - one step Mantoux dated June 12, 2023, and read on June 16, 2023, indicated ULP-B was negative for TB. ULP-B's record lacked a TB history and symptom screen and the second step Mantoux completed at hire. ULP-E ULP-E started employment with licensee March 22, 2023. ULP-E's QuantiFERON - TB Gold Plus results dated May 4, 2023, indicated ULP-E was positive for TB. ULP-E's record also included a chest X-ray dated July 14, 2021, with a negative result.	0 660		

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0 660	Continued From page 8 ULP-E's record lacked a TB history and symptom screen and a two-step Mantoux upon hire. On November 7, 2023, at 1:30 p.m., clinical nurse supervisor (CNS)-A stated all licensee's employees completed either a 2-step Mantoux or TB Gold at hire. When asked about ULP-B and ULP-E's Mantoux results, CNS-A stated she had started work with the licensee two weeks ago. The Minnesota Department of health's Assisted Living Resources & Frequently Asked Questions (FAQs) indicated baseline TB screening includes: - assessing for current symptoms of active TB disease; - assessing TB history; and - testing for the presence of Mycobacterium tuberculosis by administering either a two-step tuberculin skin test (TST) or single TB blood test. The licensee's undated Tuberculosis Screening policy indicated each employee or volunteer having direct contact with residents must have documentation of baseline health symptom screening prior to providing care to residents. This includes, at a minimum, health symptom screening, TB skin testing via the Mantoux method. This testing includes the pre-placement evaluation, administration and interpretation of TB Mantoux skin tests and periodic evaluation based on facility risk assessment or a negative IGRA (blood test) No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		

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0 680	Continued From page 9	0 680		
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 licensee failed to maintain a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all residents under the assisted living license. 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	0 680		

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0 680	Continued From page 10 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 undated EPP lacked evidence of the following required content: - EP program patient population; - development of EPP policies and procedures; - subsistence needs for staff and residents including emergency lighting; - procedures for tracking of staff and patients; - policies and procedures including evacuation; - policies and procedures for sheltering; - policies and procedures for medical documents; - policies and procedures for volunteers; - roles under a wavier declared by secretary; - primary/alternate means for communication - methods for sharing information; - sharing information on occupancy/needs; - LTC family notifications; - emergency prep training and testing; - emergency prep testing requirements; and - integrated health systems. On November 7, 2023, at 2:15 p.m., operations director (OD)-D stated licensee had reviewed the EPP with engineering surveyor and was aware of the missing content. OD-D also state licensee was not sure what the EPP requirements were. The licensee's undated Emergency Management Policy indicated [licensee] will have an identified plan in place to ensure the safety and well-being of residents and employees during periods of an emergency or a disaster that disrupts facility	0 680		

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0 680	Continued From page 11 services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the	0 730		

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0 730	Continued From page 12 resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to complete a discharge summary for one of one discharged resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: R1 was discharged from the licensee on October 5, 2023. R1's record lacked a discharge summary. On November 6, 2023, at 3:30 p.m., clinical nurse	0 730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38864	A. BUILDING: _____ B. WING _____	11/10/2023

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0 730	Continued From page 13 supervisor (CNS)-A stated R1's record lacked a discharge summary. CNS-A stated she had just started employment with licensee and was not sure how discharge documentation was handled. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
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. (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.	0 810		

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0 810	Continued From page 14 (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 a record review and interview, the licensee failed to develop a fire safety and evacuation plan with the required elements, failed to provide required employee and resident training on fire safety and evacuation, and failed to conduct required evacuation drills. This 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 November 7, 2023, from 12:30 p.m. to 2:30 p.m., survey staff toured the facility with operations director (OD)-D. It was observed the posted evacuation diagrams in the facility did not show the location and number of resident rooms. There were no labels or numbers on any of the diagrams to identify which spaces were resident rooms compared to non-resident rooms. Fire Safety and Evacuation Plan	0 810		

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0 810	Continued From page 15 On November 7, 2023, OD-D provided documentation on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of the available documentation indicated the licensee did not have employee actions to be taken in the event of a fire or similar emergency. The fire safety and evacuation plan did not provide complete actions for employees to take in the event of a fire or similar emergency and included only instructions to evacuate without specific directions. Record review of the available documentation indicated the licensee did not have fire protection procedures necessary for residents included in the fire safety and evacuation plan. Record review of the available documentation indicated the fire safety and evacuation plan did not include 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. The facility plan did include some provisions for the relocation of residents but did not specify how to move or evacuate residents or identify the unique and unusual needs of the residents. During interview on November 7, 2023 at 2:30 p.m., OD-D verified the fire safety and evacuation plan for the facility lacked these provisions. Training Record review of available documentation indicated the licensee did not provide employee training on the fire safety and evacuation plan twice per year after the training at initial hire.	0 810		

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0 810	Continued From page 16 Record review of the available documentation indicated that the licensee did not provide annual training to residents who can assist in their own evacuation on the proper actions to take in the event of a fire including movement, evacuation, or relocation as required by statute. During interview on November 7, 2023 at 2:30 p.m., OD-D stated the licensee did not have documentation on employee training on the fire safety and evacuation plan.OD-D stated that the facility did not have documentation on offering resident training on the fire safety and evacuation plan. Drills Record review of the available documentation indicated the licensee did not conduct evacuation drills twice per year per shift and every other month as required by statute. During interview on November 7, 2023 at 2:30 p.m., OD-D verified the lack of drills. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable;	0 910		

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0 910	Continued From page 17 (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for all the licensee's 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 the residents). The findings include: On November 6, 2023, at 1:10 p.m., operations director (OD)-D provided the surveyor with a blank contract and stated the same contract was used for all licensee's residents. The licensee's Resident Contract for Assisted Living lacked documentation of the Health Facility Identification (HFID) number of the facility in a conspicuous place and manner. On November 6, 2023, at 2:30 p.m., OD-D stated licensee was not aware of the requirement and all resident contracts were missing the HFID number. No further information was provided.	0 910		

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0 910	Continued From page 18 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 910		
0 950 SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the	0 950		

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0 950	Continued From page 19 licensee failed to include the required statutory language on a document separate from the contract for all the licensee's 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: On November 6, 2023, at 1:10 p.m., operations director (OD)-D provided the surveyor with a blank contract and stated the same contract was used for all licensee's residents. The licensee's Resident Contract for Assisted Living lacked the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." On November 6, 2023, at 2:30 p.m., OD-D stated licensee was not aware of the contract	0 950		

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0 950	Continued From page 20 requirement and all resident records were missing the notice with the verbiage. The licensee's undated Assisted Living Contract policy indicated the licensee must offer the resident the opportunity to identify a representative in writing on the contract and must provide the required notice on a document separate from the contract. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 950		
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 licensee's liability for health, safety, or personal property of a resident for all licensee's 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	0 970		

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0 970	Continued From page 21 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: On November 6, 2023, at 1:10 p.m., operations director (OD)-D provided the surveyor with a blank contract and stated the same contract was used for all licensee's residents. The licensee's Resident Contract for Assisted Living had two sections under Provisions Related to Liability with liability language: - Section Damage of Injury to Resident of Resident's Property read - we are not responsible for any damage or injury suffered by you, your property, your guests or their property that was not caused by us. - Section Acts of Third Parties read - we are not responsible for the actions of, or for any damages, injury or harm caused by the actions of, third parties (such as other residents, guests, intruders or trespassers) who are not under our direct and actual control. On November 6, 2023, at 2:30 p.m., OD-D stated licensee was not aware of the liability language used in the contract and the same contract was used for all licensee's residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		

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01540	Continued From page 22	01540		
01540 SS=F	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure direct-care staff completed at least eight hours of initial dementia care training within 80 working hours of the employment start date for two of two employees (unlicensed personnel (ULP)-B, 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) 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).	01540		

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	38864	A. BUILDING: _____ B. WING _____	11/10/2023

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UNIFIED HEALTH CARE	6940 ZANE AVENUE NORTH BROOKLYN PARK, MN 55429

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01540	Continued From page 23 The findings include: ULP-B ULP-B started employment with the licensee on June 29, 2023, to provide assisted living services. The licensee's Staff Schedule for the week of November 6, 2023, through November 12, 2023, indicated ULP-B was working four eight-hour shifts and two five-hour shifts that week for a total of 50 hours. ULP-B's dementia training transcript included the following topic for only one credit: 1. dementia - a refresher ULP-B's record lacked at least eight (8) hours of required of initial dementia training within 80 working hours of the employment start date. ULP-E ULP-E started employment with licensee March 22, 2023, to provide assisted living services. The licensee's Staff Schedule for the week of November 6, 2023, through November 12, 2023, indicated ULP-E was working eleven eight-hour shifts that week for a total of 88 hours. ULP-E's dementia training transcript included the following topics: 1. dementia activities (0.5 credit); 2. dementia communication overview (1 credit); 3. dementia problem solving - overview (0.75 credits); and 4. dementia activities- a balanced approach (0.75 credits). ULP-E had a total of three (3) hours of initial dementia training out of the eight (8) hours of	01540		

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01540	Continued From page 24 required initial dementia training within 80 working hours of the employment start date. On November 7, 2023, at 2:45 p.m., operations director (OD)-D stated upon hire, ULP-B and ULP-E were assigned dementia training topics to complete. OD-D also stated licensee was not aware of the required hours of dementia training. The licensee's undated Dementia Care Training policy indicated for assisted living facilities with dementia care, direct care employees must have completed at least eight hours of initial training within 80 working hours of employment start date. Until this training is complete, an employee must not provide care unless there is another employee on site who has completed the training and can act as a resource and assist if issues arise. A trainer of the requirements or a supervisor must be available for consultation with the new employee until the training requirement is complete. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01540		
01640 SS=F	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	01640		

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01640	Continued From page 25 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 interview and record review, the licensee failed to ensure the current service plan included a signature or other authentication by the resident and the facility to document agreement on the services to be provided for two of two residents (R2, 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 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 was admitted to the licensee for assisted living services June 28, 2023. R2's unsigned undated service plan indicated R2	01640		

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UNIFIED HEALTH CARE	6940 ZANE AVENUE NORTH BROOKLYN PARK, MN 55429

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01640	Continued From page 26 received the following services: housekeeping and laundry, shopping, transportation, dressing, grooming, bathing, medication administration, dining reminders, nail care, oral care reminders, blood pressure monitoring, behavior management and trash removal. R3 R3 was admitted to the licensee for assisted living services September 26, 2023. R3's unsigned undated service plan indicated R3 received the following services: ostomy care, housekeeping and laundry, shopping, transportation, dressing, grooming, bathing, medication management, dining reminders, nail care, oral care reminders, blood pressure monitoring, behavior management and trash removal. R2 and R3's service plan lacked a signature or authentication by both the facility representative and R2 and R3 or their representative documenting agreement on the services to be provided. On November 7, 2023, at 2:45 p.m., operations director (OD)-D stated licensee was not aware of the requirement to have the service plan signed. OD-D also stated none of the residents' service plan was signed by the facility and by the resident documenting agreement on the services to be provided. The licensee's undated Service Plan policy indicated the service plan shall be signed by the resident or financially responsible party. The policy lacked the verbiage for service plan was to be signed by the facility.	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38864	A. BUILDING: _____ B. WING _____	11/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIFIED HEALTH CARE	6940 ZANE AVENUE NORTH BROOKLYN PARK, MN 55429

(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
01640	Continued From page 27 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use	01730		

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01730	Continued From page 28 to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop an individual medication management plan (IMMP) to include all required content for two of two residents (R2, 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 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 November 7, 2023, at 1:56 p.m., the surveyor reviewed R2 and R3's medication administration record (MAR), service plan, and service checkoff forms, none contained the required information for IMMP. R2 R2's unsigned undated service plan indicated R2 received the following services: medication administration, dining reminders, nail care, oral	01730		

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01730	Continued From page 29 care reminders, blood pressure monitoring, behavior management, and trash removal. R3 R3's unsigned undated service plan indicated R3 received the following services: ostomy care, medication management, dining reminders, nail care, oral care reminders, blood pressure monitoring, behavior management, and trash removal. R2 and R3's record lacked an IMMP with the following content: - a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; - identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; - identification of medication management tasks that may be delegated to unlicensed personnel; - procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and - any resident-specific requirements relating to documenting medication administration. On November 7, 2023, at 2:15 p.m., clinical nurse supervisor (CNS)-A stated none of the licensee resident's record would have an IMMP as licensee had not implemented a form with this content, but any available information would be in the resident medication administration record (MAR). The licensee's undated Individualized Medication Management Plan and Record policy indicated licensee will develop an individualized medication	01730		

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01730	Continued From page 30 management plan and record based on the nursing assessment and the needs or preferences of the residents. This plan will be developed with the resident and/or resident's representative and this plan will be part of the resident's service plan. Also, the policy included a description of the medication management services that will be provided below: - a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions is listed on the MAR and in the RN assessment; - documentation of specific resident instructions relating to the administration of medications for our staff on your MAR; - identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; - identification of medication management tasks that may be delegated to unlicensed personnel are listed on your MAR; - Procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services as listed on the instructions to the ULP; and - any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		

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01820	Continued From page 31	01820		
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 interview and record review, the licensee failed to ensure written or electronically recorded prescriptions were obtained for one of one resident (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) 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: R2's diagnoses were bipolar disorder, post-traumatic stress disorder (PTSD), generalized anxiety disorder, and Parkinson's disease R2's unsigned undated service plan indicated R2 received the following services: medication administration, dining reminders, nail care, oral care reminders, blood pressure monitoring, behavior management, and trash removal. R2's Medication Administration Record (MAR), dated October 1, 2023, through October 30, 2023, listed the medications, times to administer,	01820		

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01820	Continued From page 32 and staff initials to indicate the resident was administered the following medication: calcitriol 0.25 microgram (mcg) take two capsules by mouth daily, duloxetine 20 milligram (mg) capsule take one tablet by mouth twice daily, ferrous sulfate 325 mg tablet take one tablet by mouth once daily, furosemide 20 mg tablet take one tablet by mouth daily, levothyroxine 137 mcg tablet take one tablet by mouth before breakfast Nuplazid 34 mg capsule take one capsule by mouth daily, divalproex 500 mg DR tablet take 3 tablets by mouth every night at bedtime, and vitamin D3 1000 unit capsule take one capsule by mouth daily. The licensee lacked written or electronically recorded prescriptions for all medications they managed for R2. On November 7, 2023, at 2:40 p.m., operations director (OD)-D stated licensee had not received written or electronically recorded prescriptions for any medications the licensee managed for the residents. CNS-A stated she had only been working for the licensee for two weeks and did not know yet if resident records had written prescriptions. The licensee's undated Medication Prescriptions and Refills policy indicated a current, written prescriber's prescription must be obtained for any medication, including an over-the-counter medication, whenever staff is responsible for setting up the medication, administering the medication or providing other medication management services for a resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	01820		

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01820	Continued From page 33 days	01820		
01910 SS=F	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 in the resident's record regarding the disposition of medication to include all the required content for one of one discharged resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive	01910		

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01910	Continued From page 34 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: R1 was discharged from the licensee on October 5, 2023. On November 6, 2023, at 3:20 p.m., operations director (OD)-D stated R1 received medication management services when R1 resided at licensee's facility. R1's record lacked a medication disposition record with required record to include: - 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. On November 6, 2023, at 3:24 p.m., clinical nurse supervisor (CNS)-A stated R1's record lacked a medication disposition record. Operations director (OD)-D stated the licensee handed all medications to R1 at discharge, but licensee did not keep record of the same. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
02110 SS=F	144G.82 Subd. 3 Policies	02110		

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02110	Continued From page 35 (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, the	02110		

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02110	Continued From page 36 licensee failed to ensure policies and procedures for assisted living with dementia care (ALFDC) were provided to residents or the resident's legal and /or designated representative at the time of move-in for two of two residents (R2, 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 is 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: R2 was admitted to the licensee on June 28, 2023. R3 was admitted to the licensee on September 26, 2023. R2 and R3's resident records lacked evidence the licensee provided a resident or resident representative policies and procedures that addressed 144G.82 Subd. 3., at the time of move-in to the facility. On November 7, 2023, at 2:55 p.m., operations director (OD)-D stated licensee had not developed and provided dementia care policies and procedures to resident or resident's family members. OD-D stated the licensee was unaware of the requirement for dementia care policies. No further information was provided.	02110		

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02110	Continued From page 37 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02110		
02140 SS=F	144G.83 Subd. 3 Supervising staff training Persons providing or overseeing staff training must have experience and knowledge in the care of individuals with dementia, including: (1) two years of work experience related to Alzheimer's disease or other dementias, or in health care, gerontology, or another related field; and(2) completion of training equivalent to the requirements in this section and successfully passing a skills competency or knowledge test required by the commissioner. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the designated person to oversee staff training in the care of individuals with dementia completed the required competency test. 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 is 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: During the entrance conference on April 25, 2023, at 10:16 a.m., clinical nurse supervisor (CNS)-A	02140		

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02140	Continued From page 38 stated she was responsible to provide direct resident cares and supervision of unlicensed staff, including dementia care training for licensee's staff. CNS-A started employment with licensee October 26, 2023. CNS-A's experience prior to assisted living was in long term care including nursing homes for over five (5) years. CNS-A's record lacked a completed skills competency or knowledge test required by the commissioner for a qualified dementia trainer. On November 7, 2023, at 2:30 p.m., operations director (OD)-D stated licensee was not aware of the dementia trainer skills competency or knowledge test required by the commissioner. The licensee's undated Dementia Care Training policy indicated a trainer of the requirements or a supervisor must be available for consultation with the new employee until the training requirement is complete. The policy lacked verbiage to include completion of training equivalent to the requirements in this section and successfully passing a skills competency or knowledge test required by the commissioner. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02140		
02170 SS=F	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA	02170		

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02170	Continued From page 39 (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to conduct an evaluation for	02170		

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02170	Continued From page 40 activities that addressed all provisions and failed to develop an individualized activity plan based on the evaluation, for one of one resident (R4). 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 the potential to affect a large portion or all of the residents). The findings include: The facility had a provisional assisted living with dementia care license, effective January 18, 2023. R4's diagnoses included type two diabetes without complications, other symptoms and signs involving cognitive functions and awareness, altered mental status, and unspecified schizophrenia. The licensee failed to develop an individualized written activity evaluation that addressed the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. On November 7, 2023, at 2:40 p.m., operations director (OD)-D stated licensee had not assessed	02170		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIFIED HEALTH CARE	6940 ZANE AVENUE NORTH BROOKLYN PARK, MN 55429

(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
02170	Continued From page 41 and completed an activity evaluation because licensee was not aware of the requirement for residents with dementia. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02170		

Minnesota Department of Health
Food, Pools and Lodging Services Section
625 N Robert St
St Paul, MN 55164
651-201-4500

Type: Full
Date: *11/07/23*
Time: 11:40:04
Report: 7963231143

Food and Beverage Establishment Inspection Report

Location:
Unified Health Care
6940 Zane Avenue N
Brooklyn Park, MN55443
Hennepin County, 27

Establishment Info:
ID #: 0042186
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/23

Operator:

Phone #:
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

MET WITH HRD NURSE SURVEYOR BERNARD NYANGENA.

UNIFIED HEALTH CARE- CURRENTLY DOING BUSINESS AT GREAT LAKES VILLA.

ESTABLISHMENT IS USING HEALTHY FOR LIFE MEALS FOR THEIR FOOD SERVICE WHICH IS A THIRD PARTY VENDOR.

I WILL CONTACT HENNEPIN COUNTY ENVIRONMENTAL HEALTH FOR THEM TO LICENSE AND INSPECT THIS FOOD SERVICE.

NO FOOD INSPECTION WAS COMPLETED BY MN DEPT OF HEALTH- FOOD, POOLS AND LODGING SERVICES SECTION.

Type: Full
Date: *11/07/23*
Time: 11:40:04
Report: 7963231143
Unified Health Care

Food and Beverage Establishment Inspection 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 7963231143 of 11/07/23.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Inspection report reviewed with person in charge and emailed.

Signed:_____
Ese O'Diah
PIC

Signed:_____
Peggy Spadafore
Sanitarian Supervisor
metro
651-201-4500
peggy.spadafore@state.mn.us