Electronically Delivered

March 10, 2025

Licensee
Assured Care
13404 Knob Hill Road
Burnsville, MN 55337

RE: Project Number(s) SL33372016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on February 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

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33372	A. BUILDING: _____ B. WING _____	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASSURED CARE	13404 KNOB HILL ROAD BURNSVILLE, MN 55337

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments 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: SL33372016 On February 3, 2025, through February 7, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were two residents; two 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.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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0 480	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are	0 480		

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. 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, 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: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated February 4, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer	0 480		

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0 480	Continued From page 3 to the FBEIR for any compliance dates.	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 contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. 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	0 550		

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0 550	Continued From page 4 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: On February 3, 2025, at 12:33 p.m., the surveyor toured the facility with licensed assisted living director (LALD)-A. There were postings on the wall near the living room that included the grievance procedure, but did not include contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. LALD-A reviewed the grievance procedure posting and stated it did not include the required ombudsman contact information nor was that information posted elsewhere in the facility. The licensee's Grievance policy dated June 4, 2024, indicated: 2. A copy of the grievance procedure is conspicuously posted in the residence with the following information: Name, phone number and email contact information for the individuals who are responsible for handling resident complaint Contact information for the state and any regional Office of Ombudsman for Long-Term Care Contact information for the Office of Ombudsman for Mental Health and Developmental Disabilities Contact information for the Minnesota Adult Abuse Reporting Center No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		

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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). The findings include: During facility tour on February 5, 2025, from 9:52 a.m. through 10:24 a.m., with licensed assisted living director (LALD)-D, it was observed that the fire extinguishers located in the kitchen and the lower level had a tag for monthly inspections but did not indicate if an annual inspection had been completed. The date on the extinguishers was	0 790		

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0 790	Continued From page 6 2022 and the extinguishers lacked records indicating annual certification and testing had been performed. Documentation is required to demonstrate fire extinguishers have been annually replaced with a new extinguisher or serviced annually by a certified technician. During the tour LALD-D stated that they would look for the annual certification documentation and email it to the surveyor. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 790		
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	0 810		

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0 810	Continued From page 7 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 interview and record review, the licensee failed to develop the fire safety and evacuation plan with required content and failed to conduct the required training. 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 February 5, 2025, at 10:27 a.m., licensed assisted living director (LALD)-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 8 FIRE SAFETY AND EVACUATION PLAN The licensees FSEP titled, Emergency Preparedness Manual, undated, failed to include the following: The FSEP did not include an evacuation map with a floor plan accurate to the building layout that showed the location and number of resident sleeping rooms. The FSEP 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 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. The plan stated to pull the nearest fire alarm, but the facility did not have manual fire alarms. The plan failed to include procedures for how staff are to complete each step. During an interview on February 5, 2025, at 10:55 a.m., LALD-D stated that their paperwork was disorganized from the survey process, and they would email the FSEP to the surveyor if they could locate it. FSEP must be readily available at all times in the facility. On February 7, 2025, at 5:05 p.m., licensed assisted living director (LALD)-A emailed the surveyor a document titled, Fire Safety, dated December 6, 2024. This document contained the same information that was reviewed on-site with LALD-D. The document did not provide complete	0 810		

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0 810	Continued From page 9 actions and procedures for staff to take in the event of fire or similar emergency at this licensed facility. No further information was provided. TRAINING Record review indicated the licensee failed to provide evacuation training based on the fire safety and evacuation plan to employees, at hire and twice per year as evident by not providing documentation of training offered or training scheduled for a future date. During an interview on February 5, 2025, at 10:55 a.m., LALD-D stated that they have drill records saved electronically. LALD-D was unable to print the documents. On February 5, 2025, at 11:06 a.m. LALD-D called licensed assisted living director (LALD)-A on the phone. LALD-A stated they would email the training documents and drill records to the surveyor. On February 7, 2025, at 5:05 p.m., LALD-A emailed the surveyor training records from a third-party provider that included basic fire prevention and procedures. The training was not specific to this facility's FSEP and did not include instruction to staff of how to respond to a fire or similar emergency or evacuate residents at this facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		

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0 970	Continued From page 10	0 970		
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. 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 dated 2024, included a clause that indicated the resident would waive the licensee's liability for health, safety, or personal property of a resident. -Page 13, fourth paragraph indicated: "Indemnification: [Licensee name] shall not be liable for any damage or injury to the resident, or any other person, or to any property, occurring on	0 970		

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0 970	Continued From page 11 the premises, or any part thereof, or in common areas thereof, and the resident agrees to hold [licensee name] harmless from any claims or damages unless caused solely by negligence of [licensee name]. It is recommended that renter's insurance be purchased at the resident's expense. Nothing contained herein is intended to create a waiver of facility liability for the health and safety or personal property of a resident." On February 6, 2025, at 3:44 p.m., licensed assisted living director (LALD)-A reviewed the licensee's current contract and stated it included the above content. LALD-A further stated this would be the contract utilized for all residents at the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01370 SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (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;	01370		

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01370	Continued From page 12 (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention 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 resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency evaluations were completed as required prior to providing direct care for one of two unlicensed personnel (ULP-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	01370		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33372	A. BUILDING: _____ B. WING _____	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASSURED CARE	13404 KNOB HILL ROAD BURNSVILLE, MN 55337

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01370	Continued From page 13 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-C was hired July 5, 2024, to provide direct care services. ULP-C's record lacked evidence of the following competencies had been completed prior to providing direct cares: - appropriate and safe techniques in personal hygiene and grooming, including: -hair care and bathing; -care of teeth, gums, and oral prosthetic devices; -care and use of hearing aids; -dressing and assisting with toileting On February 6, 2025, at 3:44 p.m., licensed assisted living director (LALD)-A reviewed ULP-C's employee file and could not find evidence of the above competency trainings. The licensee's Staff Competency policy dated June 4, 2024, indicated: 3. Training and competency evaluations for all unlicensed personnel include the following. e. Appropriate and safe techniques in personal hygiene and grooming, including hair care and bathing; care of teeth, gums and oral prosthetic devices; care and sue of hearing aids; and dressing and assisting with toileting. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		

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01500	Continued From page 14	01500		
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 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.	01500		

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01500	Continued From page 15 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 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 observation, interview, and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment for one of one employee (unlicensed personnel (ULP)-B). 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-B was hired January 1, 2018, to provide	01500		

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01500	Continued From page 16 direct care services. ULP-B's employee record lacked evidence the employee had successfully completed annual training as required, to include the following: - Review of provider's policies and procedures; and - Principles of person-centered planning/service delivery On February 6, 2025, at 3:44 p.m., licensed assisted living director (LALD)-A reviewed ULP-B's employee record and could not find evidence of the above required annual trainings. The licensee's Staff Orientation and Education policy dated June 4, 2024, indicated: 12. All staff providing assisted living services will complete at least eight (8) hours of education for every twelve (12) months of employment. 13. Education topics will include, but not be limited to, the following: c. Review of the organization's policies and procedures related to provision of assisted living services and how to implement them. f. The principles of person-centered planning and service delivery and how they apply to direct support services provided by staff. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility	01730		

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01730	Continued From page 17 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 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.	01730		

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01730	Continued From page 18 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an individualized medication management plan with the required content for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on February 3, 2025, at 11:35 a.m., licensed assisted living director (LALD)-A stated the licensee provided medication management services to the licensee's residents. R1's diagnoses included type II diabetes, depression, urinary retention and coronary artery disease. R1's service plan dated January 21, 2025, indicated R1 received services including medication administration. R1's physician orders dated July 3, 2024, included one medication for diabetes, one for depression, one for high cholesterol, one for benign prostatic hyperplasia, one antiplatelet (to prevent blood clots), and one corticosteroid. On February 4, 2025, at 9:47 a.m., the surveyor	01730		

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01730	Continued From page 19 observed unlicensed personnel (ULP)-B administering medication to R1. R1's individual medication management plan lacked: - identification of persons responsible for monitoring medication supplies and ensuring that medication refills were ordered on a timely basis. During a phone interview on February 5, 2025, at 10:11 a.m., clinical nurse supervisor (CNS)-E stated having access to review R1's current individual medication management plan dated November 11, 2024. CNS-E did not confirm or deny the plan was missing the above content and stated she would have to get back to the surveyor on that. The surveyor did not hear back from CNS-E. The licensee's Service Plan for Medication Management policy dated June 4, 2024, indicated: 1. The written Medication Management Plan includes the following provisions. e. Identification of person(s) responsible for monitoring medications supplies and ensuring refills are ordered/timely No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01790 SS=E	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide	01790		

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01790	Continued From page 20 medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident,	01790		

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01790	Continued From page 21 and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) developed training and competencies for the unlicensed personnel (ULP) providing medications for residents with unplanned time away from home when the licensed nurse was not available for two of two unlicensed personnel (ULP-B and ULP-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 a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings included:	01790		

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01790	Continued From page 22 ULP-B was hired to provide direct care to the licensee's residents on January 1, 2018. ULP-C was hired to provide direct care to the licensee's residents on July 5, 2024. ULP-B and ULP-C's employee record lacked documentation of competencies for providing medications to residents with medication management who have unplanned time away from home. On February 5, 2025, at 10:11 a.m., clinical nurse supervisor (CNS)-E stated she trained the unlicensed personnel to set up resident medications for leave of absence; however, she was unsure if there was a signed competency form to evidence the training. On February 6, 2025, at 3:44 p.m., licensed assisted living director (LALD)-A stated being unable to find evidence of the above training for ULP-B and ULP-C. The licensee's Medication Management Plan for Residents Away from Home policy dated June 4, 2024, indicated: 2. For unplanned times away from home for temporary periods when an adequate medication supply cannot be obtained from the pharmacy or set up by the registered nurse in a timely manner, the registered nurse may delegate to an unlicensed personnel (home heath aide) to provide the medications based on the following a. The registered nurse has trained the home heath aide and determined the home heath aide competency to follow procedures for giving medications to residents b. The registered nurse has instructed the home heath aide to ensure that all appropriate	01790		

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01790	Continued From page 23 precautions are taken. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
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 document in the resident's record the disposition of the medication including the quantity of each medication for one of one discharged resident (R3).	01910		

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01910	Continued From page 24 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R2 was admitted to the licensee on March 21, 2023, with diagnoses including atrial fibrillation, and discharged on December 10, 2024, to another facility. R2's service plan dated January 10, 2024, indicated services included medication administration. R2's Medication Disposition form dated December 19, 2024, included medications that had been sent with R2 upon discharge. The document identified the medication name, strength, and signature of the nurse and staff member transporting R2 to the admitting facility. The document did not include the quantity for any of the identified medications including: acetaminophen, albuterol inhaler, anti-diarrheal tablets, Aquaphor ointment, aspirin, digoxin (atrial fibrillation), furosemide (water pill), hydroxyzine (antihistamine), melatonin (sleep), methimazole (antithyroid), metoprolol (beta-blocker for heart), risperidone (antipsychotic), senna (constipation), sertraline (antidepressant), and triamcinolone cream (to treat skin conditions). On February 6, 2025, at 3:44 p.m. licensed assisted living director (LALD)-A reviewed R2's Medication Disposition form and stated it did not	01910		

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01910	Continued From page 25 include the quantity of each medication sent with the resident. The licensee's Disposition and Disposal of Medications policy dated June 4, 2024, indicated: 5. Upon disposition, the licensee will document the following information in the clinical record a. Name, strength and prescription number of medication, as applicable b. Quantity c. Method of disposition or to whom the medications were given d. Date of disposition e. Name(s)/signature(s) of staff or other individuals involved in disposition f. If applicable, to whom the medications were given. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		

Minnesota Department Of Health
Food, Pools, and Lodging Services
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *02/04/25*
Time: 10:30:45
Report: 1050251026

Food and Beverage Establishment Inspection Report

Location:
Assured Care
13404 Knob Hill Road
Burnsville, MN55337
Dakota County, 19

Establishment Info:
ID #: 0033367
Risk: Low
Announced Inspection: No

License Categories:

Expires on: / /

Operator:
Nuline Solutions Inc.

Phone #: 9522903003
ID #: 47227

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

4-602.12

MN Rule 4626.0850 Clean the food contact surfaces of cooking and baking equipment and interior cavities of microwave ovens at least every 24 hours.

OBSERVED INSIDE OF MICROWAVE CAVITY WITH FOOD BUILD UP. DISCUSSED ESTABLISHING A CLEANING FREQUENCY TO AVOID BUILD UP. COMPLY WITH RULE ABOVE.

Comply By: 02/04/25

Surface and Equipment Sanitizers

Hot Water: = at 160F Degrees Fahrenheit
Location: DIswasher
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding/Milk
Temperature: 35F Degrees Fahrenheit - Location: Reach-In Cooler
Violation Issued: No

Process/Item: Cold Holding/Cheese
Temperature: 36F Degrees Fahrenheit - Location: Reach-In Cooler
Violation Issued: No

Process/Item: Cold Holding/Deli Meat
Temperature: 37F Degrees Fahrenheit - Location: Reach-In Cooler
Violation Issued: No

Type: Full
Date: *02/04/25*
Time: 10:30:45
Report: 1050251026
Assured Care

Food and Beverage Establishment Inspection Report

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

Announced inspection completed by MDH Andrew Spaulding and Patricia Davis on 2/4/25.

Current pest management contract with Ecoshield with services conducted monthly. No pest issues seen on site during time of inspection.

Facility had two residents on site at time of inspection. Meals are prepared on site
This establishment has a residential kitchen. Food must be prepared for same day service only. The kitchen has wood cabinets with a hollow base and vinyl plank flooring. All found to be in good condition.

Discussed the following:
-Employee illness policy and logging requirements
-Hand washing
-Glove-use and bare hand contact
-Food storage and preventing cross contamination
-Date marking
-Vomit clean up procedures/ Kit purchase
-Restrictions concerning serving a highly susceptible population.

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 1050251026 of 02/04/25.

Certified Food Protection Manager: Tasheta Barnes

Certification Number: FM26438 Expires: 12/02/27

Inspection report reviewed with person in charge and emailed.

Signed: _____

Patricia Davis
Operator

Signed: _____

Andrew Spaulding
Public Health Sanitarian 2
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