Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF REMOVAL OF CONDITIONAL LICENSE

Electronic Delivery

March 19, 2025

Licensee
Minnesota Group Homes LLC
6322 Pleasant Avenue South
Richfield, MN 55423

RE: License Number 414861
Health Facility Identification Number (HFID) 36733
Project Number(s) SL36733015

Dear Licensee:

On March 4, 2025, The Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed August 7, 2024. The follow-up survey found the facility to be in substantial compliance. Based on these findings, the condition(s) on the license were removed effective March 19, 2025.

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.

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.

Sincerely,

Rick Michals, J.D.
Executive Regional Operations Manager

Minnesota Department of Health
Health Regulation Division

HHH

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF CONDITIONAL LICENSE

Electronically Delivered

December 10, 2024

Licensee
Minnesota Group Homes LLC
6322 Pleasant Avenue South
Richfield, MN 55423

RE: Conditional License Number 414861
Health Facility Identification Number (HFID) 36733
Project Number(s) SL36733015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a follow-up survey on October 26, 2024, for the purpose of assessing compliance with state licensing statutes. Based on the follow-up survey results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, pursuant to Minn. Stat. § 144G.20, MDH is issuing a 90-day conditional license due to expire on **March 10, 2025**.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on August 7, 2024, found not corrected at the time of the October 26, 2024, follow-up and/or subject to penalty assessment are as follows:

0470-Minimum Requirements-144g.41 Subdivision 1 - $3,000.00
0580-Quality Management-144g.42 Subd. 2 - $500.00
0660-Tuberculosis Prevention And Control-144g.42 Subd. 9 - $500.00
0680-Disaster Planning And Emergency Preparedness-144g.42 Subd. 10 - $500.00
0950-Designation Of Representative-144g.50 Subd. 3
1290-Background Studies Required-144g.60 Subdivision 1 - $3,000.00
1370-Training And Evaluation Of Unlicensed Personn-144g.61 Subd. 2 (a) - $500.00
1380-Training And Evaluation Of Unlicensed Personn-144g.61 Subd. 2 (b) - $500.00
1440-Supervision Of Staff Providing Delegated Nurs-144g.62 Subd. 4
1470-Content Of Required Orientation-144g.63 Subd. 2 - $500.00
1500-Required Annual Training-144g.63 Subd. 5 - $500.00
1530-Training In Dementia Care Required-144g.64 - $500.00
1620-Initial Reviews, Assessments, And Monitoring-144g.70 Subd. 2 (c-E) - $500.00
1940-Individualized Treatment Or Therapy Managemen-144g.72 Subd. 3 - $500.00
2310-Appropriate Care And Services-144g.91 Subd. 4 (a) - $500.00

The details of the violations noted at the time of this follow-up completed on October 26, 2024 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

MDH may assess fines based on the level and scope of the orders outlined below. The total amount of **potential** fines that may be assessed related to these correction orders is $3,000.00. **MDH is not imposing these fines against your license at this time.**

0250-Conditions-144g.20 Subdivision 1
0340-Correction Orders-144g.30 Subd. 5 - $3,000.00
1880-Storage Of Medications-144g.71 Subd. 19

The details of the violation(s) noted at the time of this follow-up are delineated on the attached State Form. Only the ID Prefix Tag in the left hand column without brackets will identify these state correction orders. It is not necessary to develop a plan of correction.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $11,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

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

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 and immediately correct any reissued orders outlined on the state form; however, plans of correction are not required to be submitted for approval. **If corrections are not made, MDH may impose fines as described above and in accordance with Minnesota Statutes 144G.**

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.

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

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

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

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

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

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

CONDITIONAL LICENSE ISSUED:
MDH will issue Minnesota Group Homes LLC a conditional assisted living facility license for 90 calendar days from the date of this notice. At an unannounced point in time, within the 90 calendar days, MDH will conduct a follow-up survey, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the follow-up survey, MDH will determine if Minnesota Group Homes LLC is in substantial compliance.

The following conditions apply on the conditional assisted living facility license:

a. **No new substantiated maltreatment allegations:** If any new investigations begin in the conditional license period, and the allegations are substantiated, MDH may pursue additional enforcement actions up to and including

immediate temporary suspension and revocation of the license.

b. No new admissions: Minnesota Group Homes LLC will not admit any new residents under its conditional assisted living facility license until MDH removes the "no new admissions" condition. Minnesota Group Homes LLC must provide the Department:

i. A list of the names and birthdates of any individuals Minnesota Group Homes LLC is currently in the process of admitting. These individuals will be able to continue the admittance process.

ii. A list of all current residents including:
1. Name and birthdate of each resident
2. Current payment source for services
3. If Elderly Waiver, the name and contact information of the care coordinator/case manager
4. If the resident is not able to make informed decisions, the name of their representative and how to contact the representative

c. Consultant: Minnesota Group Homes LLC will contract with an RN to provide consultation concerning all resident(s) to whom Minnesota Group Homes LLC provides licensed assisted living services under the conditional license. The consultant must have access to all resident(s) receiving services from Minnesota Group Homes LLC. The consultant will conduct initial and ongoing evaluations of the provider. Direct resident observation may be required based on the consultant's judgement or at the discretion of MDH. The RN must not have any affiliation with Minnesota Group Homes LLC and MDH must review the RN's credentials and approve the selection. Minnesota Group Homes LLC is responsible for the expense of the contract with the RN. The main purpose of the consultant is to provide guidance to Minnesota Group Homes LLC in an effort to help Minnesota Group Homes LLC align their practices with the requirements of Minn. Stat. §§ 144G.01 – 144G.9999 and to provide oral and written reports to MDH noting progress toward substantial compliance and/or concerns about observations. Minnesota Group Homes LLC will develop and implement policies, procedures, and processes specific to the offered services in accordance with the guidance provided by the consultant to ensure ongoing monitoring and substantial compliance with statutory requirements.

d. Reports: The RN consultant will provide MDH with regular reports at intervals specified by MDH. Reports will begin on a weekly basis until MDH notifies Minnesota Group Homes LLC and the RN consultant about a change. Each report will be electronically submitted to Brandon Mueller, State Evaluation Team, Health Regulation Division, at Brandon.W.Mueller@state.mn.us. Brandon

Mueller can be reached at 651-247-2064 (office) with questions about reports. The content of the reports will include information such as:

i. Progress towards correction of orders;
ii. Observations of staff delivering assisted living services and the level of competency observed;
iii. Conversations with residents and family members about satisfaction with assisted living services;
iv. Conversations with staff about their level of knowledge about the tasks they perform, the people they serve and the health professionals who delegate to them;
v. Overall impressions about the quality of the assisted living services delivered;
vi. Overall impressions about the dignity with which the residents and their family members are treated;
vii. Concerns; and
viii. Any other information requested by the Department or considered important by the RN consultant(s).

e. **Monitoring visits:** MDH may make unannounced monitoring visits to assess the progress of Minnesota Group Homes LLC to correct the violations cited during the follow-up survey as well as to determine the overall practice of Minnesota Group Homes LLC in meeting the needs of the people it serves. In addition, the Office of Ombudsman for Long-Term Care (OOLTC) may also make unannounced monitoring visits to determine the level of satisfaction of those people who receive licensed assisted living services. The OOLTC will share their findings with MDH.

f. **Follow-up survey:** At the time of the follow-up survey, MDH may pursue additional enforcement actions, up to and including immediate temporary suspension or revocation of the license if MDH identifies any level 3 or 4 violations or widespread care related violations.

g. **Corrective Action Plan:** Minnesota Group Homes LLC will develop and work within a corrective action plan (CAP). The CAP is a working document that includes at least the following information:
    i. A statement of the concern
    ii. A description of what will happen to correct the concern
    iii. A target date for when each correction will be complete
    iv. Who is responsible to make sure it happens
    v. Current status of correction work
    vi. Description of a plan to monitor and ensure ongoing substantial compliance for each corrected order

RESULTS OF FOLLOW-UP EVALUATION DURING THE CONDITIONAL LICENSE PERIOD:
MDH will determine if Minnesota Group Homes LLC is in substantial compliance based on the results of the follow up survey. MDH will make this determination within the 90-day conditional license period. If MDH determines Minnesota Group Homes LLC is in substantial compliance on the follow up survey, MDH will remove the conditions from Minnesota Group Homes LLC's assisted living facility license, and Minnesota Group Homes LLC will correct any outstanding violations identified during the survey. If Minnesota Group Homes LLC is not in substantial compliance on the follow-up survey, MDH may take additional enforcement action, up to and including immediate temporary suspension and revocation, as authorized by Minn. Stat. § 144G.20.

REQUESTING A HEARING:
Pursuant to Minn. Stat. §144G.20, Subd. 18, the licensee may appeal an action against the license under this section. The licensee must request a hearing no later than 15 business days after licensee receives notice of the action.

To submit a hearing request, please visit
https://forms.web.health.state.mn.us/form/HRD-Appeals-Form.

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 Brandon Mueller directly at: 651-247-2064.

Sincerely,

Rick Michals, J.D.
Executive Regional Operations Manager
Minnesota Department of Health
Health Regulation Division

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36733	A. BUILDING: _____ B. WING _____	R 10/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINNESOTA GROUP HOMES LLC	6322 PLEASANT AVENUE SOUTH RICHFIELD, MN 55423

(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 In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been 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: SL36733015-1 On October,23, 2024, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on August 7, 2024. At the time of the survey, there were three residents; receiving services under the Assisted Living license. As a result of the follow-up survey, the following orders were reissued.	{0 000}	Minnesota Department of Health is documenting the State Licensing 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. Not reviewed during this survey	
0 250 SS=F	144G.20 Subdivision 1 Conditions	0 250		

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0 250	Continued From page 1 (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living	0 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 250	Continued From page 2 facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the management officials who were in charge of the day-to-day operations; and responsible for the resident's assisted living services, understood all of the assisted living facility regulations. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 "Application for Assisted Living License", section titled "Official Verification of Owner or Authorized Agent", (page four and five	0 250	Not reviewed during this survey	

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0 250	Continued From page 3 of the application), identified, "I certify I have read and understand the following:" [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45 (opens in a new window), my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17 (opens in a new window). - I have read and fully understand Minn. Stat. sect. 144G.80 (opens in a new window), 144G.81 (opens in a new window). and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22 (opens in a new window), my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G (opens in a new window). - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659 (proposed and not final) (opens in a new window). - Reporting of Maltreatment of Vulnerable Adults (opens in a new window). - Electronic Monitoring in Certain Facilities (opens in a new window)." - "I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G (opens in a new window), and Minnesota Rules, chapter 4659 (proposed and not final) (opens in a new window), governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract." - "I have examined this application and all attachments and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of	0 250		

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0 250	Continued From page 4 my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required." - I attest to have all required policies and procedures of Minn. Stat. chapter 144G (opens in new window). and Minn. Rules chapter 4659 (proposed and not final) (opens in new window), in place upon licensure and to keep them current as applicable." Page five was electronically signed by the owner on November 21, 2023. The licensee had an assisted living license, effective January 2, 2024. 18 correction orders were issued, which indicated the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.01 to 144G.95. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250		
0 340 SS=I	144G.30 Subd. 5 Correction orders a) A correction order may be issued whenever the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, an agent of the facility, or an employee of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail or email copies	0 340		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 340	Continued From page 5 of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide sufficient documentation with actions taken to comply with the correction orders from a survey completed August 7, 2024. The lack of action to ensure compliance with regulations had the potential to affect all residents receiving services from the licensee. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: On August 7, 2024, at 1:30 p.m., the licensee was	0 340	Not reviewed during this survey	

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0 340	Continued From page 6 provided an exit email related to the conclusion of the licensee's survey. The email was reviewed with clinical nurse supervisor (CNS)-B and included a link hosted on the Minnesota Department of Health's website for the Correction Order Documentation Guidelines document. On September 19, 2024, at 9:13 a.m., the licensee received the results of the survey concluded on August 7, 02024. The longest time period for correction (the time frame the licensee must document and correct orders) was 21 days from the date the licensee received their results. This date was October 10, 2024. On October 23, 2024, at 9:00 a.m., the surveyor arrived to initiate of the licensee's revisit survey. On October 23, 2024, at 1:00 p.m., housing manager (HM)-A stated they have not corrected any correction orders. They have a meeting with a consultant on Friday and they were going to go over everything at that time. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 340		
{0 470} SS=I	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans	{0 470}		

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{0 470}	Continued From page 7 on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure sufficient staffing to meet the needs of one of one resident (R1), who required two person transfers. This resulted in an immediate correction order on August 7, 2024, and again on October 23, 2024. In addition, the licensee failed to develop and implement a staffing plan and evaluate it twice a year to determine the appropriateness of staffing levels in the facility. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that	{0 470}	Not reviewed during this survey	

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{0 470}	Continued From page 8 has affected or has potential to affect a large portion or all the residents). The findings include: The licensee lacked sufficient staffing to meet R1's needs on a 24-hour basis as required by R1's care plan. On August 5, 2024, at 10:30 a.m., during the entrance conference, clinical nurse supervisor (CNS)-B stated the facility schedule was one unlicensed personnel (ULP) for each eight-hour shift identified as 7:00 a.m.-3:00 p.m., 3:00 p.m.-11:00 p.m., 11:00 p.m.-7:00 a.m. R1's Client Care Plan, dated December 12, 2021, indicated R1 required total assistance with transfers and needed two people to transfer R1 to his bed and chair and for all R1's transfers. On August 6, 2024, at 3:40 p.m., clinical nurse supervisor (CNS)-B stated R1 needed a two person transfer for his safety, and if one person did it (transferred R1), R1 grabs and pulls on staff. On August 6, 2024, at 3:47 p.m., the surveyor observed two staff transfer R1 from his wheelchair to his bed. The licensee's undated posted staffing schedule indicated the following: -Monday through Sunday administration 7:00 a.m. - 9:00 p.m. -Monday one ULP 7:00 a.m.-3:00 p.m., one ULP 3:00 p.m.-9:00 p.m., and two ULP 11:00 p.m.-7:00 a.m. -Tuesday one ULP 7:00 a.m.-3:00 p.m., one ULP 3:00 p.m.-9:00 p.m., one ULP 11:00 p.m.-7:00	{0 470}		

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{0 470}	Continued From page 9 a.m. and nurse 11:00 a.m.-8:00 p.m. -Wednesday one ULP 7:00 a.m.-3:00 p.m., one ULP 3:00 p.m.-9:00 p.m., one ULP 11:00 p.m.-7:00 a.m. -Thursday one ULP 7:00 a.m.-3:00 p.m., one ULP 3:00 p.m.-9:00 p.m., one ULP 11:00 p.m.-7:00 a.m. -Friday one ULP 7:00 a.m.-3:00 p.m., two ULP's 11:00 p.m.-7:00 a.m. -Saturday one ULP 3:00 p.m.-9:00 p.m., one ULP 1:00 p.m.-10:00 p.m., two ULP 11:00 p.m.-7:00 a.m. -Sunday one ULP 3:00 p.m.-9:00 p.m., one ULP 1:00 p.m.-10:00 p.m., two ULP 11:00 p.m.-7:00 a.m. and the nurse 11:00 a.m.-8:00 p.m. On August 7, 2024, at 9:00 a.m., housing manager (HM)-A stated he covers any open shifts including the daily gap from 9:00 p.m.-11:00 p.m. On August 7, 2024, at 11:36 a.m., clinical nurse supervisor (CNS)-B stated they have a staffing plan but cannot find it. CNS-B further stated they staff according to assessment and acuity and will continue looking for the plan. On October 23, 2024, at 11:00 a.m., the surveyor observed the posted staffing schedule which indicated the following: -Monday- administration 7:00 a.m.-6:00 p.m. and Tuesday-Sunday 7:0 a.m.-11:00 p.m. -Monday 1 ULP 7:00 a.m.-3:00 p.m., 2 RN 11:00 a.m.-8:00 p.m., 1 ULP 6:00 p.m.-11:00 p.m., 2 ULP 11:00 p.m.-7:00 a.m. -Tuesday 1 ULP 7:00 a.m.-3:00 p.m., 1 ULP 3:00 p.m.-9:00 p.m., 1 ULP 7:00 p.m.-1:00 p.m., 1 ULP 11:00 p.m.-7:00 a.m. -Wednesday 1 ULP 7:00 a.m.-7:00 p.m., 1 ULP 7:00 p.m.-11:00 p.m., 2 ULP 11:00 p.m.-7:00 a.m. -Thursday 1 ULP 7:00 a.m.-3:00 p.m., 1 RN 11:00	{0 470}		

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{0 470}	Continued From page 10 a.m.-8:00 p.m., 1 ULP 3:00 p.m.-9:00 p.m., 1 ULP 9:00 p.m.-7:00 a.m., 1 ULP 11:00 p.m.-7:00 a.m. -Friday 1 ULP 7:00 a.m.-3:00 p.m., 1 ULP 3:00 p.m.-9:00 p.m., 1 ULP 6:00 p.m.-11:00 p.m., 1 ULP 11:00 p.m.-7:00 a.m. -Saturday 1 ULP 7:00 a.m.-11:00 p.m., 1 ULP 3:00 p.m.-9:00 p.m., 2 ULP 11:00 p.m.-7:00 a.m. -Sunday 1 ULP 7:00 a.m.-11:00 p.m., 1 RN 11:00 a.m.-8:00 p.m., 1 ULP 3:00 p.m.-9:00 p.m., 1 ULP 11:00 p.m.-7:00 a.m. On October 3, 2024, at 1:42 p.m., housing manager (HM)-A stated he created a new schedule and added some employees to the overnight shift, but the schedule provided at entrance did not have two staff on all shifts. HM-A further stated he created the new schedule today. The licensee's Staffing & Scheduling policy dated February 1, 2024, indicated the clinical nurse supervisor will develop and implement a written staffing plan that provides an adequate number of qualified direct-care staff to meet the resident's needs 24-hours a day, seven-days a week. The clinical nurse supervisor must ensure that staffing levels are adequate to address the following: Each resident's needs, as identified in the resident's service plan and assisted living contract. Each resident's acuity level, as determined by the most recent assessment or individualized review. The ability of staff to timely meet the resident's scheduled and reasonably foreseeable unscheduled needs given the physical layout of the facility premises. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	{0 470}		

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{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by:	{0 480}	Not reviewed during this survey.	
{0 580} SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to implement and maintain a quality management program appropriate to the size of the facility and relevant to the type of services provided. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a	{0 580}	Not reviewed during this survey	

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{0 580}	Continued From page 12 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On August 5, 2024, at 10:30 a.m. clinical nurse supervisor (CNS)-B stated they have meetings every three months but was unable to find any documentation of the quality management meetings. On October 23, 2024, at 1:53 p.m., clinical nurse supervisor (CNS)-B stated the quality management plan had not been fully developed. The licensee's undated Quality Improvement policy indicated [the facility] has established a quality improvement program on the organization's size and appropriate to the type of services provided to assure that effective, comprehensive, and appropriate plans are operational for all clients with the organization [the facility] shall engage in quality management plan relevant to the type of services [the facility] provides. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	{0 580}		
{0 660} SS=F	144G.42 Subd. 9 Tuberculosis prevention and control	{0 660}		

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{0 660}	Continued From page 13 (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 maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included an updated TB risk assessment for the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: The facility's TB risk assessment was dated July 13, 2020, and included a different address than	{0 660}	Not reviewed during this survey	

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{0 660}	Continued From page 14 the one for the facility. The facility's TB facility risk assessment dated July 13, 2020, indicated the TB risk assessment would be conducted or updated annually and/or following risk of exposure. The facility did not review the TB risk assessment annually. On August 7, 2024, at 11:53 a.m. CNS-B stated she had updated the risk assessment but would have to look for it. CNS-B was not able to find the current risk assessment. On October 23, 2024, at 12:30 p.m., the surveyor reviewed the TB facility risk assessment dated October 22, 2023. On October 23, 2024, at 1:30 p.m. clinical nurse supervisor (CNS)-B stated she was working on the TB risk assessment but was waiting on the consultant who is supposed to come later that week. The Minnesota Department of Health guidelines Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, and based on CDC guidelines, indicated a TB infection control program should include an annual facility TB risk assessment. The guidelines also indicated an employee may begin working with patients (residents) after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW starts working with patients. Baseline TB screening should be documented in the employee's record.	{0 660}		

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{0 660}	Continued From page 15 The licensee's Tuberculosis Screening policy dated February 1, 2024, indicated the facility will maintain a current community TB risk assessment. The assessment will be updated annually, using the data and form provided by the Minnesota Department of Health. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	{0 660}		
{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.	{0 680}		

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{0 680}	Continued From page 16 (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 have a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all visitors, employees, and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 the residents). The findings include: The licensee's undated EPP lacked documentation including all the required elements of: -annual review -quarterly review of missing persons policy -EP program patient population -process for EP collaboration -development of EP policies and procedures -subsistence needs for staff and patients -policies and procedures including evacuation -arrangements with other facilities -development of communication plan -names and contact information -emergency officials contact information -primary/alternate means for communication -emergency prep training and testing -emergency prep training program	{0 680}	Not reviewed during this survey	

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{0 680}	Continued From page 17 -emergency prep testing requirements On October 23, 2024, at 10:00 a.m., housing manager (HM)-A stated the emergency plan had not been fully developed because they were waiting on the consultant they hired to come and meet with them. The licensee's Emergency Preparedness Plan-Appendix Z Compliance policy dated February 1, 2024, indicated [the facility] emergency preparedness plan will include all required elements of appendix z. The plan will be in writing and reviewed annually. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	{0 680}		
{0 800} SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by:	{0 800}	Not reviewed during this survey	
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment	{0 810}		

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{0 810}	Continued From page 18 (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. (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:	{0 810}	Not reviewed during this survey	

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{0 950}	Continued From page 19	{0 950}		
{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 licensee failed to offer the resident the opportunity to identify a designated representative in writing with the required statutory language for one of one resident (R1).	{0 950}	Not reviewed during this survey	

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{0 950}	Continued From page 20 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: R1's Assisted Living Contract was signed by R1's representative but was undated. R1's assisted living contract failed to include statute statement from 144.50 subd. 3 with required verbatim 'right to designate a representative for certain purposes' on a separate page in the contract. On August 7, 2024, at 12:14 p.m., clinical nurse supervisor (CNS)-B stated she was not aware of this requirement. On October 23, 2024, at 1:30 p.m., housing manager (HM)-A asked what the designated representative page was and that he had not updated the contracts. HM-A further stated he does not have a designated rep form for any of the residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	{0 950}		
{01290} SS=I	144G.60 Subdivision 1 Background studies required	{01290}		

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	36733	A. BUILDING: _____ B. WING _____	R 10/26/2024

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{01290}	Continued From page 21 (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure COVID expired background studies were completed for two of nine employees (unlicensed personnel/ ULP-G and ULP-H) on the facility provided employee roster. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: On August 6, 2024, at 2:50 p.m., the surveyor reviewed the facility's NETStudy 2.0 roster and	{01290}	Not reviewed during this survey	

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{01290}	Continued From page 22 compared it to the facility's staff roster and discovered only two of the facility's seven employees were affiliated with the licensee's HFID 36733. ULP-C was hired on October 6, 2021, to provide direct care and services to the licensee's residents. A background study had not been submitted for ULP-C. ULP-D was hired on July 10, 2020, to provide direct care and services to the licensee's residents. A background study had not been submitted for ULP-D. ULP-E was hired on October 8, 2021, to provide direct care and services to the licensee's residents. A background study had not been submitted for ULP-E. ULP-F was hired on October 20, 2021, to provide direct care services to the licensee's residents. A background study had not been submitted for ULP-F. ULP-G was hired on October 20, 2022, to provide direct care services to the licensee's residents. ULP-G had a COVID-19 background study, which expired on December 31, 2022; an updated background study had not been submitted for ULP-G. On August 6, 2024, at 3:10 p.m., housing manager (HM)-A stated he had used the wrong address and HFID for the background studies and further stated he did not know the COVID-19 studies had to be redone. On October 23, 2024, at 11:00 a.m., the surveyor reviewed the facility's NETStudy 2.0 roster and	{01290}		

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{01290}	Continued From page 23 compared it to the facility's staff roster/schedule. Two employees had expired COVID studies. ULP-G was hired on October 20, 2022, to provide direct care services to the licensee's residents. ULP-G had a COVID-19 background study, which expired on December 31, 2022; an updated background study had not been submitted for ULP-G. ULP-H unknown hire date had a COVID-19 background study which expired on December 31, 2021; an updated background study had not been submitted for ULP-H. On October 23, 2024, at 11:25 a.m., HM-A stated the two staff with COVID expired background studies have not been fingerprinted yet. The licensee's Background Studies policy dated February 1, 2024, indicated [the facility] will conduct a Minnesota Department of Human Services background study on all employees and volunteers and contractors at [the facility]. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	{01290}		
{01370} SS=F	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	{01370}		

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{01370}	Continued From page 24 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; 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 observation, interview, and record review, the licensee failed to ensure required training was completed for one of one employee (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a	{01370}	Not reviewed during this survey	

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{01370}	Continued From page 25 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: ULP-C began employment on October 6, 2021, to provide direct care services. ULP- C was observed providing direct care services to residents on August 6, 2024. ULP-C's employee record lacked documentation of the following competency evaluations to be completed by ULP: -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 -standby assistance techniques and how to perform them On August 6, 2024, at 3:47 p.m., ULP-C stated he was a certified nursing assistant and looked online at the CNA registry and could not find his name. ULP-C also drove home to find his certificate but was unable to find it. On August 7, 2024, at 12:21 p.m., clinical nurse supervisor (CNS)-B stated when ULP-C was hired he was on the certified nursing assistant registry and still is and that is why he did not complete the competency testing. CNS-B was unable to find the certificate. On October 23, 2024, at 1:30 p.m., housing	{01370}		

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{01370}	Continued From page 26 manager (HM)-A and CNS-B stated the employees have not completed any further training since the last survey. The licensee's Competency Training Evaluations policy dated February 1, 2024, indicated training and competency evaluations of ULPs will be conducted by a registered nurse (RN), or another instructor may provide training in conjunction with a RN. Training and competency evaluations for all ULPs will include: 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. Standby assistance techniques and how to perform them. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	{01370}		
{01380} SS=F	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive,	{01380}		

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{01380}	Continued From page 27 and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency evaluations for the required topics were completed by one of one 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: ULP-C began employment on October 6, 2021, to provide direct care services. ULP- C was observed providing direct care services to residents on August 6, 2024. ULP-C's employee record lacked documentation of the following training and competency evaluations to be completed by ULP: -reading and recording temperature, pulse, and respirations of the resident -safe transfer techniques and ambulation -range of motion and positioning -administering medications or treatments as required -other RN/professionally delegated tasks	{01380}	Not reviewed during this survey	

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{01380}	Continued From page 28 On August 6, 2024, at 3:47 p.m., ULP-C stated he was a certified nursing assistant and looked online at the CNA registry and could not find his name. ULP-C also drove home to find his certificate but was unable to find it. On August 7, 2024, at 12:21 p.m., clinical nurse supervisor (CNS)-B stated when ULP-C was hired he was on the certified nursing assistant registry and still is and that is why he did not complete the competency testing. CNS-B was unable to find the certificate. On October 23, 2024, at 1:30 p.m., housing manager (HM)-A and CNS-B stated the employees have not completed any further training since the last survey. The licensee's Competency Training Evaluations policy dated February 1, 2024, indicated training and competency evaluations of ULPs will be conducted by a RN or another instructor may provide the training in conjunction with a registered nurse (RN). Training and competency evaluations for all ULPs will include: -reading and recording temperature, pulse, and respirations of the resident -safe transfer techniques and ambulation -range of motion and positioning -administering medications or treatments as required -other RN/professionally delegated tasks No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	{01380}		

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{01440}	Continued From page 29	{01440}		
{01440} SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a registered nurse (RN) conducted direct supervision of staff performing a delegated task within 30 days of providing services for one of one employee (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	{01440}	Not reviewed during this survey	

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{01440}	Continued From page 30 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-C began employment on October 6, 2021, to provide direct care services. ULP- C was observed providing direct care services which included a transfer assist to a resident on August 6, 2024. ULP-C's employee record lacked documentation of direct supervision of performing a delegated task within 30 days of providing services to verify the work was performed competently and to identify problems and solutions to address issues relating to the staff's ability to provide the services. On August 7, 2024, at 12:21 p.m., clinical nurse supervisor (CNS)-B stated the 30-day supervision for ULP-C was completed but is not sure where the documentation is and will send it to the surveyor by the end of the day. On August 8, 2024, at 7:00 a.m., the surveyor received a 30-day staff performance review document via email, dated July 18, 2024. On October 23, 2024, at 1:30 p.m., CNS-B stated she had not completed 30-day supervisions for staff within 30 days. The licensee's Supervision of Staff- Delegated Services policy dated February 1, 2024, indicated direct supervision of staff performing delegated tasks must be provided within 30 calendar days	{01440}		

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{01440}	Continued From page 31 after the date on which the individual begins working for [the facility] and first performs the delegated tasks for residents and thereafter as needed based on performance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	{01440}		
{01470} SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care	{01470}		

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{01470}	Continued From page 32 Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) 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 interview and record review, the licensee failed to ensure orientation to assisted living facility licensing requirements and regulations included all required content for one of one employee (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) and was issued at a	{01470}	Not reviewed during this survey	

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{01470}	Continued From page 33 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: ULP-C began employment on October 6, 2021, to provide direct care services. ULP- C was observed providing direct care services to residents on August 6, 2024. ULP-C's employee record lacked the following required orientation content: -overview of assisted living statutes -the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights -review of the types of assisted living services the employee will provide and provider's scope of license -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person On August 7, 2024, at 12:18 p.m., clinical nurse supervisor (CNS)-B stated they were not aware they were assigning the incorrect classes in Educare (online training). CNS-B further stated all staff were assigned the 144A training instead of the 144G training. On October 23, 2024, at 1:30 p.m., housing manager (HM)-A and CNS-B stated the employees have not completed any further training since the last survey. The licensees Orientation of Staff and Supervisors & Content policy dated February 1, 2024, indicated all staff of the facility providing	{01470}		

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{01470}	Continued From page 34 and supervising direct services must complete an orientation to Assisted Living facility licensing requirements and regulations before providing assisted living services to residents. The orientation must include the following topics: -an overview of the appropriate Assisted Living statutes and rules -the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights -principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person -a review of the types of assisted living services the employee will be providing and the facility's category of licensure No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	{01470}		
{01500} SS=F	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	{01500}		

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{01500}	Continued From page 35 techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication	{01500}		

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{01500}	Continued From page 36 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 an employee received at least eight hours of annual training for each 12 months of employment for one of one employee (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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: ULP-C began employment on October 6, 2021, to provide direct care services. ULP- C was observed providing direct care services to residents on August 6, 2024. ULP-C's record lacked evidence of annual training to include: -reporting maltreatment of vulnerable adults or minors -assisted living bill of rights - 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 - review of provider's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures	{01500}	Not reviewed during this survey	

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{01500}	Continued From page 37 - principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff On August 7, 2024, at 12:18 p.m., clinical nurse supervisor (CNS)-B stated she was not aware they had not been assigning the correct classes in Educare (online training) for staff annual training and this was the same for all employees. On October 23, 2024, at 1:30 p.m., housing manager (HM)-A and CNS-B stated the employees have not completed any further training since the last survey. The licensee's Annual Required Staff Training policy dated February 1, 2024, indicated all staff that perform direct care services at [the facility] will complete at least eight (8) hours of annual training for each 12 months of employment. The following training elements MUST be included every 12 months to all staff who performs direct care services: -training on reporting of maltreatment of vulnerable adults under section 626.557 -review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights -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 -effective approaches to use to problem solve when working with a resident's challenging	{01500}		

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{01500}	Continued From page 38 behaviors and ow to communicate with residents who have dementia, Alzheimer's disease or related disorders -review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures -principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	{01500}		
{01530} SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 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	{01530}		

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{01530}	Continued From page 39 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 observation, interview, and record review, the licensee failed to ensure employees received eight hours of initial dementia care training within the first 160 hours worked for one of one employee (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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: ULP-C began employment on October 6, 2021, to provide direct care services. ULP- C was observed providing direct care services to residents on August 6, 2024. ULP-C's orientation and training record lacked documentation of the required number of hours of dementia care training. The training record dated October 1, 2021, included: -Dementia- the Face of Dementia- the Journey 1.0 -Dementia introduction and overview 1.0 -Dementia 2- Communication 1.25 -Dementia 3 Activities of Daily Living 1.0	{01530}	Not reviewed during this survey	

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{01530}	Continued From page 40 -Dementia 4 Behaviors vs Symptoms 1.0 -Dementia 5 the Journey .75 On August 7, 2024, at 12:20 p.m., clinical nurse supervisor (CNS)-B stated ULP-C only had six hours of dementia training instead of the required eight hours and was not sure why. CNS-B further stated the same courses were assigned to all staff. On October 23, 2024, at 1:30 p.m., housing manager (HM)-A and CNS-B stated the employees have not completed any further training since the last survey. The licensee's Dementia Training policy dated February 1, 2024, indicated direct care employees will complete eight (8) hours of initial training within 160 hours of the employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	{01530}		
{01620} SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an	{01620}		

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{01620}	Continued From page 41 individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to ensure the registered nurse (RN) used the uniform assessment tool for ongoing assessments and monitoring 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On August 5, 2024, at 10:30 a.m., clinical nurse supervisor (CNS)-B stated the licensee completed initial, 14-day, 90-day, and change in condition assessments. R1 was admitted and began receiving services on	{01620}	Not reviewed during this survey	

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{01620}	Continued From page 42 October 6, 2021. R1's most recent assessment (unsigned) dated July 15, 2024, did not include all the required elements on the uniform assessment tool. R1's assessment lacked: -personal lifestyle preferences, including sleep schedule, dietary and social needs, leisure activities, and any other customary routine that is important to the resident's quality of life, spiritual and cultural preferences, and advance health care directives and end-of-life preferences -activities of daily living, including toileting pattern, bowel, and bladder control, dressing, grooming, bathing, and personal hygiene, mobility, including ambulation, transfers, and assistive devices, and eating, dental status, oral care, and assistive devices and dentures -instrumental activities of daily living including ability to self-manage medications, housework and laundry and transportation -physical health status including a review of relevant health history and current health conditions, including medical and nursing diagnoses, allergies and sensitivities related to medication, seasonality, environment, and food and if any of the allergies or sensitivities are life threatening, infectious conditions, a review of medications according to Minnesota Statutes section 144G.71 subdivision 2 including prescriptions, over-the-counter medications, and supplements, and for each, the reason taken, any side effects, contraindications, allergic or adverse reactions and actions to address these issues, the dosage, the frequency of use, the route administered or taken, any difficulties the resident faces in taking the medication, whether the resident self-administers the medication, the resident's preferences in how to take the medication, interventions needed in management	{01620}		

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{01620}	Continued From page 43 of medications to prevent diversion of medication by the resident or others who may have access to the medications, and provide instructions to the resident and resident's legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications, a review of medical, dental, and emergency room visits in the past 12 months, including visits to a primary health care provider, hospitalizations, surgeries, and care from a post-acute care facility, a review of any reports from a physical therapist, occupational therapist, speech therapist, or cognitive evaluations within the last 12 months, and weight -emotional and mental health conditions, including review of history of and any diagnoses of mood disorders, including depression, anxiety, bipolar disorder, and thought or behavioral disorders, current symptoms of mental health conditions and behavioral expressions of concerns and effective treatment and nonmedication interventions -cognition, including a review of any neurocognitive evaluations and diagnoses and current memory, orientation, confusion, and decision-making status and ability -communication and sensory capabilities, including hearing, vision, speech, assistive communication, and sensory devices including hearing aids and the ability to understand and be understood -pain, including location, frequency, intensity, and duration and effectiveness of medication and nonmedication alternatives -skin conditions -nutritional and hydration status and preferences -list of treatments including type, frequency, and level of assistance needed -nursing needs, including potential to receive nursing-delegated services	{01620}		

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{01620}	Continued From page 44 -risk indicators, including risk for falls including history of falls, emergency evacuation ability, complex medication regimen, risk for dehydration, including history of urinary tract infections and current fluid intake pattern, risk for emotional or psychological distress due to personal losses, unsuccessful prior placements, elopement risk including history or previous elopements, smoking including the ability to smoke without causing burns or injury to the resident or others or damage property and alcohol and drug use, including the resident's alcohol use or drug use not prescribed by a physician. -who has decision-making authority for the resident, including the presence of any advance health care directive or other legal document that establishes a substitute decision maker and the scope of decision-making authority of a substitute decision maker -the need for follow up referrals for additional medical or cognitive care by health professionals On August 6, 2024, at 3:40 p.m., clinical nurse supervisor (CNS)-B stated she was unaware of the uniform assessment tool requirement and had been using old forms for all resident assessments. On October 23, 2024, at 12:40 p.m., CNS-B stated she had not completed updated assessments for the residents using the uniform assessment tool. The Minnesota Administrative Rule 4659.0150 dated August 11, 2021, indicated each facility must develop a uniform assessment tool to include all the required elements. The licensee's Assessments, Reviews, &	{01620}		

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{01620}	Continued From page 45 Monitoring policy dated February 1, 2024, indicated the initial nursing assessment or reassessment must include all the elements of the uniform assessment tool as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	{01620}		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure all medications were securely locked in substantially constructed compartments and permit only authorized personnel had access. 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 the residents). The findings include: On August 6, 2024, at 10:40 a.m., the surveyor observed the refrigerator in the kitchen and noted	01880	Not reviewed during this survey	

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01880	Continued From page 46 R1's box of Lantus insulin was stored, unsecured in the refrigerator. On August 7, 2024, at 12:11 p.m., clinical nurse supervisor (CNS)-B stated they used to have a small refrigerator for storing the medication and it was kept locked, but it quit working 3-4 days ago and they are in the process of getting a new one. On October 23, 2024, at 10:00 a.m., CNS-B showed the surveyor a small refrigerator they had to store the insulin. The refrigerator was stored in an unlocked cabinet. The licensee's Medication Storage policy dated February 1, 2024, indicated when medications are managed and stored by [the facility], medications will be kept securely locked and stored per manufacturer's directions. Only authorized staff will have access to stored medications. No further information was provided. TIME PERIOD TO CORRECT: Seven (7) days.	01880		
{01940} SS=F	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following:	{01940}		

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{01940}	Continued From page 47 (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all 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 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:	{01940}	Not reviewed during this survey	

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{01940}	Continued From page 48 R1 had diagnoses to include cerebral paraplegia and type II diabetes. On August 6, 2024, at 8:10 a.m., the surveyor observed housing manager (HM)-A check R1's blood glucose. R1's Client Care Plan HHA (home health aide) dated October 8, 2021, indicated R1 received the following treatments and therapies: Passive range of motion daily Assist with special equipment daily, resident uses a stander. Blood sugar checks twice daily Temperature, blood pressure, oxygen, and respiration daily R1's undated treatment plan indicated R1 received: Range of motion on right leg and arm daily Use stander daily. R1's record failed to include: A current, dated treatment/therapy plan. Written instructions for each treatment or therapy Resident-specific instructions related to documentation of all treatments and/or therapies administered. Or reason not administered, verified as administered and monitored to prevent complications or adverse reactions. Provider orders current and renewed annually for all provided treatments or therapies. Procedures to notify a RN when problems arose with treatments or therapies. R1's service plan dated October 2, 2023, did not include any of the above treatments. On August 7, 2024, at 12:16 p.m., clinical nurse	{01940}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36733	A. BUILDING: _____ B. WING _____	R 10/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINNESOTA GROUP HOMES LLC	6322 PLEASANT AVENUE SOUTH RICHFIELD, MN 55423

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{01940}	Continued From page 49 supervisor (CNS)-B stated she cannot find a current treatment or therapy plan and will have to keep looking around for it. The one she found was undated and stated she knew it was missing information. CNS-B further stated R1's blood glucose checks are maybe on a different piece of paper. On October 23, 2024, at 1:30 p.m., CNS-B stated she has not completed the treatment plan for R1. The licensee's Treatment & Therapy Management Plan policy dated February 1, 2024, indicated for each resident at [the facility] receiving management of ordered or prescribed treatments or therapy services, the facility will prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. [the facility] will develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: -a statement of the type of services that will be provided -documentation of specific resident instructions relating to the treatments or therapy administration -identification of treatment or therapy tasks that will be delegated to unlicensed personnel -procedures for notifying a registered nurse when a problem arises with treatments or therapy services -any resident-specific requirements relating to documentation of treatment and therapy received -verification that all treatment and therapy was administered as prescribed -monitoring of treatment or therapy to prevent possible complications or adverse reactions Treatment or therapy management record must	{01940}		

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{01940}	Continued From page 50 be current and updated when there are any changes. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	{01940}		
{02310} SS=F	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the care and services were provided according to acceptable health care and medical, or nursing standards for one of one resident (R1) with hospital-style bed rails. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On August 6, 2024, at 8:20 a.m., the surveyor observed R1's bed rails attached to the hospital	{02310}	Not reviewed during this survey	

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{02310}	Continued From page 51 bed. R1 was admitted and began receiving services on December 6, 2021. R1's diagnoses include cerebral paraplegia and type II diabetes. R1's service plan dated October 2, 2023, indicated R1 received assist with dressing, bathing, medication administration, meal assistance, laundry, and housekeeping. R1's Bed Safety Assessment dated January 1, 2024, included: - an assessment - the risk vs. benefit were discussed and documented with the resident family. R1's assessment lacked: -the rails were FDA compliant - measurements that were completed and documented. On August 7, 2024, at 12:17 p.m., clinical nurse supervisor (CNS)-B stated the bed rail assessment was missing the measurements because she forgot to measure the zones. CNS-B was not sure about the bed rails being FDA compliant. On October 23, 2024, at 1:30 p.m., CNS-B stated she had not completed the measurements for R1's bed rail after the initial survey. The Food and Drug Administration's (FDA) A Guide to Bed Safety Bed Rails in Hospitals Nursing Homes and Home Health Care dated June 21, 2006, indicated the following information: "Patients who have problems with	{02310}		

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{02310}	Continued From page 52 memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) last updated April 3, 2024, indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Installation and use according to manufacturer's guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated	{02310}		

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{02310}	Continued From page 53 risk agreements". Additionally, the MDH website indicated for hospital-style bed rails, the licensee must include in their documentation, the bed rail measurements and that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendations. The licensee's Side Rails policy dated February 1, 2024, indicated when [the facility] is aware a home care resident is utilizing side rails (a medical device) on a bed, [the facility] will assess the use, educate the resident, and when appropriate, the responsible person, regarding the risks and benefits of side rails, and verify that the side rail use is of safe design and utilized consistent with the manufacturer's directions. Staff from [the facility] will determine if the side rail is considered to be safe. "Safe" shall be defined as meeting all of the requirements listed including the side rial design is consistent with the FDA's 2006 recommended dimensional measurements to reduce entrapment. This means side rail zones 1, 2, and 3 must not exceed 4.75". No further information provided. TIME PERIOD FOR CORRECTION: Two (2) days	{02310}		

Electronically Delivered

September 19, 2024

Licensee
Minnesota Group Homes LLC
6322 Pleasant Avenue South
Richfield, MN 55423

RE: Project Number(s) SL36733015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 7, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. MDH documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

IMPOSITION OF FINES

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

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

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

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

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

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

St - 0 - 0470 - 144g.41 Subdivision 1 - Minimum Requirements - $3,000.00
St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $6,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for

hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. to submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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

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

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

If you have any questions, please contact me.

Sincerely,

Kelly Thorson, Supervisor
State Evaluation Team
Email: kelly.thorson@state.mn.us
Telephone: 320-223-7336 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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: SL36733015 On August 5, 2024, through, August 7, 2024, 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 three resident(s); three receiving services under the provider's Assisted Living Facility license. An immediate correction order was identified on August 6, 2024, issued for SL36733015-0, tag identification 0820. On August 7, 2024, the immediacy of correction order 0820 was removed, however non-compliance remained at an scope and level of I.	0 000	Minnesota Department of Health is documenting the State Licensing 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.	

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0 470	Continued From page 1	0 470		
0 470 SS=I	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure sufficient staffing to meet the needs of one of one resident (R1), who required two person transfers. This resulted in an immediate correction order on August 7, 2024. In addition, the licensee failed to develop and implement a staffing plan and	0 470		

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0 470	Continued From page 2 evaluate it twice a year to determine the appropriateness of staffing levels in the facility. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: The licensee lacked sufficient staffing to meet R1's needs on a 24-hour basis as required by R1's care plan. On August 5, 2024, at 10:30 a.m., during the entrance conference, clinical nurse supervisor (CNS)-B stated the facility schedule was one unlicensed personnel (ULP) for each eight-hour shift identified as 7:00 a.m.-3:00 p.m., 3:00 p.m.-11:00 p.m., 11:00 p.m.-7:00 a.m. R1's Client Care Plan, dated December 12, 2021, indicated R1 required total assistance with transfers and needed two people to transfer R1 to his bed and chair and for all R1's transfers. On August 6, 2024, at 3:40 p.m., clinical nurse supervisor (CNS)-B stated R1 needed a two person transfer for his safety, and if one person did it (transferred R1), R1 grabs and pulls on staff. On August 6, 2024, at 3:47 p.m., the surveyor observed two staff transfer R1 from his wheelchair to his bed.	0 470		

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0 470	Continued From page 3 The licensee's undated posted staffing schedule indicated the following: -Monday through Sunday administration 7:00 a.m. - 9:00 p.m. -Monday one ULP 7:00 a.m.-3:00 p.m., one ULP 3:00 p.m.-9:00 p.m., and two ULP 11:00 p.m.-7:00 a.m. -Tuesday one ULP 7:00 a.m.-3:00 p.m., one ULP 3:00 p.m.-9:00 p.m., one ULP 11:00 p.m.-7:00 a.m. and nurse 11:00 a.m.-8:00 p.m. -Wednesday one ULP 7:00 a.m.-3:00 p.m., one ULP 3:00 p.m.-9:00 p.m., one ULP 11:00 p.m.-7:00 a.m. -Thursday one ULP 7:00 a.m.-3:00 p.m., one ULP 3:00 p.m.-9:00 p.m., one ULP 11:00 p.m.-7:00 a.m. -Friday one ULP 7:00 a.m.-3:00 p.m., two ULP's 11:00 p.m.-7:00 a.m. -Saturday one ULP 3:00 p.m.-9:00 p.m., one ULP 1:00 p.m.-10:00 p.m., two ULP 11:00 p.m.-7:00 a.m. -Sunday one ULP 3:00 p.m.-9:00 p.m., one ULP 1:00 p.m.-10:00 p.m., two ULP 11:00 p.m.-7:00 a.m. and the nurse 11:00 a.m.-8:00 p.m. On August 7, 2024, at 9:00 a.m., housing manager (HM)-A stated he covers any open shifts including the daily gap from 9:00 p.m.-11:00 p.m. On August 7, 2024, at 11:36 a.m., clinical nurse supervisor (CNS)-B stated they have a staffing plan, but cannot find it. CNS-B further stated they staff according to assessment and acuity and will continue looking for the plan. The licensee's Staffing & Scheduling policy dated February 1, 2024, indicated the clinical nurse supervisor will develop and implement a written staffing plan that provides an adequate number of	0 470		

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0 470	Continued From page 4 qualified direct-care staff to meet the resident's needs 24-hours a day, seven-days a week. The clinical nurse supervisor must ensure that staffing levels are adequate to address the following: Each resident's needs, as identified in the resident's service plan and assisted living contract. Each resident's acuity level, as determined by the most recent assessment or individualized review. The ability of staff to timely meet the resident's scheduled and reasonably foreseeable unscheduled needs given the physical layout of the facility premises. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	0 480		

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MINNESOTA GROUP HOMES LLC	6322 PLEASANT AVENUE SOUTH RICHFIELD, MN 55423

(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
0 480	Continued From page 5 or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated August 5, 2024, 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 to the FBEIR for any compliance dates.	0 480		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to implement and maintain a quality management program appropriate to the size of the facility and relevant to the type of services provided. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a	0 580		

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0 580	Continued From page 6 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On August 5, 2024, at 10:30 a.m. clinical nurse supervisor (CNS)-B stated they have meetings every three months, but was unable to find any documentation of the quality management meetings. The licensee's undated Quality Improvement policy indicated [the facility] has established a quality improvement program on the organization's size and appropriate to the type of services provided to assure that effective, comprehensive, and appropriate plans are operational for all clients with the organization [the facility] shall engage in quality management plan relevant to the type of services [the facility] provides. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 580		
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	0 660		

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0 660	Continued From page 7 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 maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included an updated TB risk assessment for the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: The facility's TB risk assessment was dated July 13, 2020, and included a different address than the one for the facility. The facility's TB facility risk assessment dated July 13, 2020, indicated the TB risk assessment	0 660		

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0 660	Continued From page 8 would be conducted or updated annually and/or following risk of exposure. The facility did not review the TB risk assessment annually. On August 7, 2024, at 11:53 a.m. CNS-B stated she had updated the risk assessment but would have to look for it. CNS-B was not able to find the current risk assessment. The Minnesota Department of Health guidelines Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, and based on CDC guidelines, indicated a TB infection control program should include an annual facility TB risk assessment. The guidelines also indicated an employee may begin working with patients (residents) after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW starts working with patients. Baseline TB screening should be documented in the employee's record. The licensee's Tuberculosis Screening policy dated February 1, 2024, indicated the facility will maintain a current community TB risk assessment. The assessment will be updated annually, using the data and form provided by the Minnesota Department of Health. No further information was 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 have a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all visitors, employees, and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	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 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 the residents). The findings include: The licensee's undated EPP lacked documentation including all the required elements of: -annual review -quarterly review of missing persons policy -hazard risk assessment -subsistence needs for staff and patients -procedures for tracking of staff and patients -policies and procedures for sheltering -policies and procedures for medical documents -policies and procedures for volunteers -roles under a waiver declared by secretary -development of communication plan -names and contact information -emergency officials contact information -primary/alternate means for communication -methods for sharing information -sharing information on occupancy/needs -LTC family notifications -emergency prep training and testing -emergency prep training program -emergency prep testing requirements On August 6, 2024, at 3:10 p.m., housing manager (HM)-A stated all the requirements of appendix z have not been met. The licensee's Emergency Preparedness Plan-Appendix Z Compliance policy dated February 1, 2024, indicated [the facility] emergency preparedness plan will include all required	0 680		

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0 680	Continued From page 11 elements of appendix z. The plan will be in writing and reviewed annually. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by:	0 780		

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0 780	Continued From page 12 Based on observation and interview, the licensee failed to provide smoke alarms that are interconnected so that the actuation of one alarm causes all alarms in the dwelling unit to actuate. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On August 6, 2024, at 10:00 a.m., survey staff toured the facility with the housing manager (HM)-A. During the facility tour, it was observed the sleeping rooms that were equipped with smoke alarms were not interconnected upon testing so actuation of one alarm would cause all alarms to operate. During the interview on August 6, 2024, at 11:00 a.m., HM-A stated the smoke alarms in the facility were not interconnected, and the actuation of one alarm would not cause all alarms to operate. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including	0 800		

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0 800	Continued From page 13 walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents and staff. 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: On August 6, 2024, at 10:00 a.m., survey staff toured the facility with the housing manager (HM)-A. During the facility tour, survey staff observed the following items: On the main entrance outside of the exit door, it was observed that burnt, used cigarettes were being disposed of without a proper disposal container, creating a possible fire hazard. During the facility tour, HM-A visually verified these deficient findings at the time of discovery.	0 800		

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0 800	Continued From page 14 TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.	0 810		

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0 810	Continued From page 15 This MN Requirement is not met as evidenced by: Based on the interview and record review, the licensee failed to provide the required training and failed to provide the required drills as required. 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, 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 August 6, 2024, at 11:30 a.m., housing manager (HM)-A provided documentation on the fire safety and evacuation plan (FSEP), fire safety and evacuation training for the facility, and fire safety and evacuation drills for the facility. TRAINING Record review of the available documentation indicated employees did not receive training twice per year after initial hire. During the interview on August 6, 2024, at 12:00 p.m., HM-A stated the licensee provided annual training on the fire safety and evacuation plan to employees, but not twice per year after the initial hire, as required by statute. HM-A confirmed there was no further documented training for the staff on the fire safety and evacuation plan as	0 810		

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0 810	Continued From page 16 required by statute. DRILLS Record review of the available documentation indicated that the licensee did not conduct evacuation drills twice per year per shift and every other month as required by statute. Provided documentation indicated that the drills were conducted on 1/4/23, 4/4/23, 10/4/23, 1/4/24 and 4/4/24, with no further drills being documented. During the interview on August 6, 2024, at 12:00 p.m., HM-A confirmed that the drills were conducted quarterly only and verified this deficient condition. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 820 SS=I	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced	0 820		

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0 820	Continued From page 17 by: Based on observation and interview, the licensee failed to ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide resident bedrooms with the minimum window opening meeting the minimum state standard for egress. This affected the occupied resident in bedroom 1, 2, and 3 on the main level. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On August 6, 2024, at 10:00 a.m., survey staff toured the facility with the housing manager (HM)-A. During the facility tour, survey staff observed the following items: It was observed that occupied resident bedroom 1, 2, and 3 on the main level did not have windows that met the minimum size requirements for egress escape. The clear openable area of the opened windows measured 15 inches in height and 37 inches in width, with a total openable area of 555 square inches. The windows did not meet the minimum requirements for opening height and did not meet the minimum requirements for total openable area. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no	0 820	This immediate correction order identified on August 6, 2024, has had the immediacy lifted as of August 7, 2024, however non-compliance remained a scope and level of I.	

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0 820	Continued From page 18 less than 648 square inches total of openable area (4.5 square feet) for the window. Survey staff explained to HM-A that at least one egress window in each bedroom must be provided to meet the minimum state standard for an egress window to be a complying bedroom for resident occupancy. HM-A verbally confirmed the findings. On August 6, 2024, at 11:00 a.m., during the interview, survey staff explained to HM-A that an immediate correction order was issued for the above finding. HM-A acknowledged the above finding. No Further information was provided. TIME PERIOD FOR CORRECTION: Immediate.	0 820		
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	0 950		

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0 950	Continued From page 19 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 licensee failed to offer the resident the opportunity to identify a designated representative in writing with the required statutory language for one of one resident (R1). 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: R1's Assisted Living Contract was signed by R1's representative but was undated. R1's assisted living contract failed to include statute statement from 144.50 subd. 3 with required verbatim 'right to designate a representative for certain purposes' on a separate page in the contract.	0 950		

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0 950	Continued From page 20 On August 7, 2024, at 12:14 p.m., clinical nurse supervisor (CNS)-B stated she was not aware of this requirement. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study was affiliated to the current health facility identification (HFID) number for five of seven employees (unlicensed personnel/ULP-C, ULP-D, ULP-E, ULP-F, ULP-G) on the facility provided employee roster. This practice resulted in a level three violation (a	01290		

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01290	Continued From page 21 violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: On August 6, 2024, at 2:50 p.m., the surveyor reviewed the facility's NETStudy 2.0 roster and compared it to the facility's staff roster and discovered only two of the facility's seven employees were affiliated with the licensee's HFID 36733. ULP-C was hired on October 6, 2021, to provide direct care and services to the licensee's residents. A background study had not been submitted for ULP-C. ULP-D was hired on July 10, 2020, to provide direct care and services to the licensee's residents. A background study had not been submitted for ULP-D. ULP-E was hired on October 8, 2021, to provide direct care and services to the licensee's residents. A background study had not been submitted for ULP-E. ULP-F was hired on October 20, 2021, to provide direct care services to the licensee's residents. A background study had not been submitted for ULP-F. ULP-G was hired on October 20, 2022, to provide direct care services to the licensee's residents.	01290		

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01290	Continued From page 22 ULP-G had a COVID-19 background study, which expired on December 31, 2022; an updated background study had not been submitted for ULP-G. On August 6, 2024, at 3:10 p.m., housing manager (HM)-A stated he had used the wrong address and HFID for the background studies and further stated he did not know the COVID-19 studies had to be redone. The licensee's Background Studies policy dated February 1, 2024, indicated [the facility] will conduct a Minnesota Department of Human Services background study on all employees and volunteers and contractors at [the facility]. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	01290		
01370 SS=F	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; (ii) care of teeth, gums, and oral prosthetic devices;	01370		

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01370	Continued From page 23 (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 observation, interview, and record review, the licensee failed to ensure required training was completed for one of one employee (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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include:	01370		

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01370	Continued From page 24 ULP-C began employment on October 6, 2021, to provide direct care services. ULP- C was observed providing direct care services to residents on August 6, 2024. ULP-C's employee record lacked documentation of the following competency evaluations to be completed by ULP: -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 -standby assistance techniques and how to perform them On August 6, 2024, at 3:47 p.m., ULP-C stated he was a certified nursing assistant and looked online at the CNA registry and could not find his name. ULP-C also drove home to find his certificate but was unable to find it. On August 7, 2024, at 12:21 p.m., clinical nurse supervisor (CNS)-B stated when ULP-C was hired he was on the certified nursing assistant registry and still is and that is why he did not complete the competency testing. CNS-B was unable to find the certificate. The licensee's Competency Training Evaluations policy dated February 1, 2024, indicated training and competency evaluations of ULPs will be conducted by a registered nurse (RN), or another instructor may provide training in conjunction with a RN. Training and competency evaluations for all ULPs will include: Appropriate and safe techniques in personal hygiene and grooming, including hair care and bathing, care of teeth, gums, and oral prosthetic	01370		

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01370	Continued From page 25 devices, care and use of hearing aids, dressing and assisting with toileting. Standby assistance techniques and how to perform them. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01380 SS=F	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency evaluations for the required topics were completed by one of one unlicensed personnel (ULP-C).	01380		

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01380	Continued From page 26 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: ULP-C began employment on October 6, 2021, to provide direct care services. ULP- C was observed providing direct care services to residents on August 6, 2024. ULP-C's employee record lacked documentation of the following training and competency evaluations to be completed by ULP: -reading and recording temperature, pulse, and respirations of the resident -safe transfer techniques and ambulation -range of motion and positioning -administering medications or treatments as required -other RN/professionally delegated tasks On August 6, 2024, at 3:47 p.m., ULP-C stated he was a certified nursing assistant and looked online at the CNA registry and could not find his name. ULP-C also drove home to find his certificate but was unable to find it. On August 7, 2024, at 12:21 p.m., clinical nurse supervisor (CNS)-B stated when ULP-C was hired he was on the certified nursing assistant registry and still is and that is why he did not complete the competency testing. CNS-B was unable to find the certificate. The licensee's Competency Training Evaluations	01380		

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01380	Continued From page 27 policy dated February 1, 2024, indicated training and competency evaluations of ULPs will be conducted by a RN or another instructor may provide the training in conjunction with a registered nurse (RN). Training and competency evaluations for all ULPs will include: -reading and recording temperature, pulse, and respirations of the resident -safe transfer techniques and ambulation -range of motion and positioning -administering medications or treatments as required -other RN/professionally delegated tasks No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30	01440		

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01440	Continued From page 28 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a registered nurse (RN) conducted direct supervision of staff performing a delegated task within 30 days of providing services for one of one employee (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 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 began employment on October 6, 2021, to provide direct care services. ULP- C was observed providing direct care services which included a transfer assist to a resident on August 6, 2024. ULP-C's employee record lacked documentation of direct supervision of performing a delegated task within 30 days of providing services to verify the work was performed competently and to identify problems and solutions to address issues relating to the staff's ability to provide the	01440		

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01440	Continued From page 29 services. On August 7, 2024, at 12:21 p.m., clinical nurse supervisor (CNS)-B stated the 30-day supervision for ULP-C was completed but is not sure where the documentation is and will send it to the surveyor by the end of the day. On August 8, 2024, at 7:00 a.m., the surveyor received a 30-day staff performance review document via email, dated July 18, 2024. The licensee's Supervision of Staff- Delegated Services policy dated February 1, 2024, indicated direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for [the facility] and first performs the delegated tasks for residents and thereafter as needed based on performance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section	01470		

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01470	Continued From page 30 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) 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	01470		

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01470	Continued From page 31 involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure orientation to assisted living facility licensing requirements and regulations included all required content for one of one employee (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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: ULP-C began employment on October 6, 2021, to provide direct care services. ULP- C was observed providing direct care services to residents on August 6, 2024. ULP-C's employee record lacked the following required orientation content: -overview of assisted living statutes -the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights -review of the types of assisted living services the employee will provide and provider's scope of license -the principles of person-centered planning and service delivery and how they apply to direct	01470		

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01470	Continued From page 32 support services provided by the staff person On August 7, 2024, at 12:18 p.m., clinical nurse supervisor (CNS)-B stated they were not aware they were assigning the incorrect classes in Educare (online training). CNS-B further stated all staff were assigned the 144A training instead of the 144G training. The licensees Orientation of Staff and Supervisors & Content policy dated February 1, 2024, indicated all staff of the facility providing and supervising direct services must complete an orientation to Assisted Living facility licensing requirements and regulations before providing assisted living services to residents. The orientation must include the following topics: -an overview of the appropriate Assisted Living statutes and rules -the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights -principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person -a review of the types of assisted living services the employee will be providing and the facility's category of licensure No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01500 SS=F	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	01500		

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01500	Continued From page 33 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. 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:	01500		

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01500	Continued From page 34 (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 an employee received at least eight hours of annual training for each 12 months of employment for one of one employee (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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: ULP-C began employment on October 6, 2021, to provide direct care services. ULP- C was observed providing direct care services to residents on August 6, 2024. ULP-C's record lacked evidence of annual training to include:	01500		

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01500	Continued From page 35 -reporting maltreatment of vulnerable adults or minors -assisted living bill of rights - 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 - review of provider's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures - principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff On August 7, 2024, at 12:18 p.m., clinical nurse supervisor (CNS)-B stated she was not aware they had not been assigning the correct classes in Educare (online training) for staff annual training and this was the same for all employees. The licensee's Annual Required Staff Training policy dated February 1, 2024, indicated all staff that perform direct care services at [the facility] will complete at least eight (8) hours of annual training for each 12 months of employment. The following training elements MUST be included every 12 months to all staff who performs direct care services: -training on reporting of maltreatment of vulnerable adults under section 626.557 -review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights -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	01500		

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01500	Continued From page 36 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 -effective approaches to use to problem solve when working with a resident's challenging behaviors and ow to communicate with residents who have dementia, Alzheimer's disease or related disorders -review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures -principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		
01530 SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working	01530		

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01530	Continued From page 37 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 observation, interview, and record review, the licensee failed to ensure employees received eight hours of initial dementia care training within the first 160 hours worked for one of one employee (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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: ULP-C began employment on October 6, 2021, to provide direct care services. ULP- C was observed providing direct care services to residents on August 6, 2024. ULP-C's orientation and training record lacked	01530		

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01530	Continued From page 38 documentation of the required number of hours of dementia care training. The training record dated October 1, 2021, included: -Dementia- the Face of Dementia- the Journey 1.0 -Dementia introduction and overview 1.0 -Dementia 2- Communication 1.25 -Dementia 3 Activities of Daily Living 1.0 -Dementia 4 Behaviors vs Symptoms 1.0 -Dementia 5 the Journey .75 On August 7, 2024, at 12:20 p.m., clinical nurse supervisor (CNS)-B stated ULP-C only had six hours of dementia training instead of the required eight hours and was not sure why. CNS-B further stated the same courses were assigned to all staff. The licensee's Dementia Training policy dated February 1, 2024, indicated direct care employees will complete eight (8) hours of initial training within 160 hours of the employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment.	01620		

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01620	Continued From page 39 (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to ensure the registered nurse (RN) used the uniform assessment tool for ongoing assessments and monitoring 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On August 5, 2024, at 10:30 a.m., clinical nurse supervisor (CNS)-B stated the licensee completed initial, 14-day, 90-day, and change in	01620		

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01620	Continued From page 40 condition assessments. R1 was admitted and began receiving services on October 6, 2021. R1's most recent assessment (unsigned) dated July 15, 2024, did not include all the required elements on the uniform assessment tool. R1's assessment lacked: -personal lifestyle preferences, including sleep schedule, dietary and social needs, leisure activities, and any other customary routine that is important to the resident's quality of life, spiritual and cultural preferences, and advance health care directives and end-of-life preferences -activities of daily living, including toileting pattern, bowel, and bladder control, dressing, grooming, bathing, and personal hygiene, mobility, including ambulation, transfers, and assistive devices, and eating, dental status, oral care, and assistive devices and dentures -instrumental activities of daily living including ability to self-manage medications, housework and laundry and transportation -physical health status including a review of relevant health history and current health conditions, including medical and nursing diagnoses, allergies and sensitivities related to medication, seasonality, environment, and food and if any of the allergies or sensitivities are life threatening, infectious conditions, a review of medications according to Minnesota Statutes section 144G.71 subdivision 2 including prescriptions, over-the-counter medications, and supplements, and for each, the reason taken, any side effects, contraindications, allergic or adverse reactions and actions to address these issues, the dosage, the frequency of use, the route administered or taken, any difficulties the resident faces in taking the medication, whether the	01620		

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01620	Continued From page 41 resident self-administers the medication, the resident's preferences in how to take the medication, interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications, and provide instructions to the resident and resident's legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications, a review of medical, dental, and emergency room visits in the past 12 months, including visits to a primary health care provider, hospitalizations, surgeries, and care from a post-acute care facility, a review of any reports from a physical therapist, occupational therapist, speech therapist, or cognitive evaluations within the last 12 months, and weight -emotional and mental health conditions, including review of history of and any diagnoses of mood disorders, including depression, anxiety, bipolar disorder, and thought or behavioral disorders, current symptoms of mental health conditions and behavioral expressions of concerns and effective treatment and nonmedication interventions -cognition, including a review of any neurocognitive evaluations and diagnoses and current memory, orientation, confusion, and decision-making status and ability -communication and sensory capabilities, including hearing, vision, speech, assistive communication, and sensory devices including hearing aids and the ability to understand and be understood -pain, including location, frequency, intensity, and duration and effectiveness of medication and nonmedication alternatives -skin conditions -nutritional and hydration status and preferences -list of treatments including type, frequency, and	01620		

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01620	Continued From page 42 level of assistance needed -nursing needs, including potential to receive nursing-delegated services -risk indicators, including risk for falls including history of falls, emergency evacuation ability, complex medication regimen, risk for dehydration, including history of urinary tract infections and current fluid intake pattern, risk for emotional or psychological distress due to personal losses, unsuccessful prior placements, elopement risk including history or previous elopements, smoking including the ability to smoke without causing burns or injury to the resident or others or damage property and alcohol and drug use, including the resident's alcohol use or drug use not prescribed by a physician. -who has decision-making authority for the resident, including the presence of any advance health care directive or other legal document that establishes a substitute decision maker and the scope of decision-making authority of a substitute decision maker -the need for follow up referrals for additional medical or cognitive care by health professionals On August 6, 2024, at 3:40 p.m., clinical nurse supervisor (CNS)-B stated she was unaware of the uniform assessment tool requirement and had been using old forms for all resident assessments. The Minnesota Administrative Rule 4659.0150 dated August 11, 2021, indicated each facility must develop a uniform assessment tool to include all the required elements. The licensee's Assessments, Reviews, & Monitoring policy dated February 1, 2024, indicated the initial nursing assessment or	01620		

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01620	Continued From page 43 reassessment must include all the elements of the uniform assessment tool as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure all medications were securely locked in substantially constructed compartments and permit only authorized personnel had access. 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 the residents). The findings include: On August 6, 2024, at 10:40 a.m., the surveyor observed the refrigerator in the kitchen and noted R1's box of Lantus insulin was stored, unsecured in the refrigerator.	01880		

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01880	Continued From page 44 On August 7, 2024, at 12:11 p.m., clinical nurse supervisor (CNS)-B stated they used to have a small refrigerator for storing the medication and it was kept locked, but it quit working 3-4 days ago and they are in the process of getting a new one. The licensee's Medication Storage policy dated February 1, 2024, indicated when medications are managed and stored by [the facility], medications will be kept securely locked and stored per manufacturer's directions. Only authorized staff will have access to stored medications. No further information was provided. TIME PERIOD TO CORRECT: Seven (7) days.	01880		
01940 SS=F	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel;	01940		

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01940	Continued From page 45 (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all 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 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: R1 had diagnoses to include cerebral paraplegia and type II diabetes. On August 6, 2024, at 8:10 a.m., the surveyor observed housing manager (HM)-A check R1's blood glucose.	01940		

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01940	Continued From page 46 R1's Client Care Plan HHA (home health aide) dated October 8, 2021, indicated R1 received the following treatments and therapies: Passive range of motion daily Assist with special equipment daily, resident uses a stander. Blood sugar checks twice daily Temperature, blood pressure, oxygen, and respiration daily R1's undated treatment plan indicated R1 received: Range of motion on right leg and arm daily Use stander daily. R1's record failed to include: A current, dated treatment/therapy plan. Written instructions for each treatment or therapy Resident-specific instructions related to documentation of all treatments and/or therapies administered. Or reason not administered, verified as administered and monitored to prevent complications or adverse reactions. Provider orders current and renewed annually for all provided treatments or therapies. Procedures to notify a RN when problems arose with treatments or therapies. R1's service plan dated October 2, 2023, did not include any of the above treatments. On August 7, 2024, at 12:16 p.m., clinical nurse supervisor (CNS)-B stated she cannot find a current treatment or therapy plan and will have to keep looking around for it. The one she found was undated and stated she knew it was missing information. CNS-B further stated R1's blood glucose checks are maybe on a different piece of paper.	01940		

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01940	Continued From page 47 The licensee's Treatment & Therapy Management Plan policy dated February 1, 2024, indicated for each resident at [the facility] receiving management of ordered or prescribed treatments or therapy services, the facility will prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. [the facility] will develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: -a statement of the type of services that will be provided -documentation of specific resident instructions relating to the treatments or therapy administration -identification of treatment or therapy tasks that will be delegated to unlicensed personnel -procedures for notifying a registered nurse when a problem arises with treatments or therapy services -any resident-specific requirements relating to documentation of treatment and therapy received -verification that all treatment and therapy was administered as prescribed -monitoring of treatment or therapy to prevent possible complications or adverse reactions Treatment or therapy management record must be current and updated when there are any changes. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36733	A. BUILDING: _____ B. WING _____	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINNESOTA GROUP HOMES LLC	6322 PLEASANT AVENUE SOUTH RICHFIELD, MN 55423

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 48	02310		
02310 SS=F	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the care and services were provided according to acceptable health care and medical, or nursing standards for one of one resident (R1) with hospital-style bed rails. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On August 6, 2024, at 8:20 a.m., the surveyor observed R1's bed rails attached to the hospital bed. R1 was admitted and began receiving services on December 6, 2021. R1's diagnoses include cerebral paraplegia and type II diabetes. R1's service plan dated October 2, 2023,	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36733	A. BUILDING: _____ B. WING _____	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINNESOTA GROUP HOMES LLC	6322 PLEASANT AVENUE SOUTH RICHFIELD, MN 55423

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02310	Continued From page 49 indicated R1 received assist with dressing, bathing, medication administration, meal assistance, laundry, and housekeeping. R1's Bed Safety Assessment dated January 1, 2024, included: - an assessment - the risk vs. benefit were discussed and documented with the resident family. R1's assessment lacked: -the rails were FDA compliant - measurements that were completed and documented. On August 7, 2024, at 12:17 p.m., clinical nurse supervisor (CNS)-B stated the bed rail assessment was missing the measurements because she forgot to measure the zones. CNS-B was not sure about the bed rails being FDA compliant. The Food and Drug Administration's (FDA) A Guide to Bed Safety Bed Rails in Hospitals Nursing Homes and Home Health Care dated June 21, 2006, indicated the following information: "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) last updated April 3, 2024, indicated, "To ensure an individual is an appropriate candidate for a bed rail, the	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36733	A. BUILDING: _____ B. WING _____	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINNESOTA GROUP HOMES LLC	6322 PLEASANT AVENUE SOUTH RICHFIELD, MN 55423

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 50 licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Installation and use according to manufacturer's guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". Additionally, the MDH website indicated for hospital-style bed rails, the licensee must include in their documentation, the bed rail measurements and that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendations. The licensee's Side Rails policy dated February 1, 2024, indicated when [the facility] is aware a home care resident is utilizing side rails (a medical device) on a bed, [the facility] will assess	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36733	A. BUILDING: _____ B. WING _____	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02310	Continued From page 51 the use, educate the resident, and when appropriate, the responsible person, regarding the risks and benefits of side rails, and verify that the side rail use is of safe design and utilized consistent with the manufacturer's directions. Staff from [the facility] will determine if the side rail is considered to be safe. "Safe" shall be defined as meeting all of the requirements listed including the side rial design is consistent with the FDA's 2006 recommended dimensional measurements to reduce entrapment. This means side rail zones 1, 2, and 3 must not exceed 4.75". No further information provided. TIME PERIOD FOR CORRECTION: Two (2) days	02310		

Minnesota Department of Health

625 Robert Street North
St Paul
651-201-4500

Type: Full
Date: *08/05/24*
Time: 11:45:38
Report: 7994241141

Food and Beverage Establishment Inspection Report

Location:

Minnesota Group Homes Llc
6322 Pleasant Avenue South
Richfield, MN55423
Hennepin County, 27

Establishment Info:

ID #: 0039069
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6519999616
ID #:

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

The following orders were issued during this inspection.

3-500B Microbial Control: hot and cold holding

3-501.16A2 ***** Priority 1 *****

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

MILK AND HOT DOGS FOUND AT 44 F. INSTRUCTED STAFF TO ADJUST FRIDGE AND MONITOR TO ENSURE FOODS ARE MAINTAINED AT OR BELOW 41 F.

Comply By: 08/05/24

4-300 Equipment Numbers and Capacities

4-302.13A ***** Priority 2 *****

MN Rule 4626.0710A Provide a readily accessible temperature measuring device for measuring the washing and sanitizing temperatures in manual warewashing operations.

NO TEST STRIPS WERE FOUND ON SITE. INSPECTOR PROVIDED TEST STRIPS AND THE FACILITY WILL EMAIL A PICTURE OF THE COMPLETED TEST STRIP LATER TODAY. (8/5/24)

Comply By: 08/05/24

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

MANAGER IS CURRENTLY STUDYING FOR EXAM BUT DOES NOT HAVE CFPM CERTIFICATE YET. PROVIDE A COPY VIA EMAIL WHEN THE CFPM CERTIFICATE IS OBTAINED.

Comply By: 08/05/24

4-200 Equipment Design and Construction

4-201.11GMN

MN Rule 4626.0506G Discontinue serving TCS foods that are held for more than same-day service in an adult or child care center or boarding establishment or provide equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

ONE RESIDENT HAS SPECIAL DIET THAT IS PREPARED AND KEPT IN THE FRIDGE. FACILITY IS KEEPING THE PORTIONS FOR UP TO 6 DAYS. THIS FOOD ITEM MAY NEED TO BE MADE EACH DAY.

Comply By: 08/05/24

6-300 Physical Facility Numbers and Capacities

6-301.14A

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

TWO COMPARTMENT SINK FOUND WITH BOTH COMPARTMENTS BEING USED FOR DIRTY DISHES. DESIGNATE AND LABEL ONE COMPARTMENT FOR A HANDWASH SINK.

Comply By: 08/05/24

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

INSPECTION CONDUCTED IN THE PRESENCE OF HRD STAFF AND FINDINGS SHARED AT THE END OF INSPECTION.

WILL EMAIL SUPPORTING DOCUMENTS AND LINKS TO HRD STAFF AT THE END OF THE DAY.

KITCHEN IS RESIDENTIAL AND FOOD IS PREPARED FOR SAME DAY SERVICE. FLOOR IS VINYL, CABINETS ARE WOOD WITH HALLOWED ENCLOSED BASES, LAMINATE COUNTER TOPS AND TEXTURED CEILING. ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT ANY TIME THERE IS FOUND TO BE A RISK OF CONTAMINATION OR CONCERN THE PHYSICAL FACILITIES WILL BE REQUIRED TO BE BROUGHT UP TO CODE.

Type: Full
Date: *08/05/24*
Time: 11:45:38
Report: 7994241141
Minnesota Group Homes Llc

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 7994241141 of 08/05/24.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed:_____
Bashir Geelle
Manager

Signed: Crystal Elva
Crystal Elva
Public Health Sanitarian 3
St Paul
651-201-3981
Crystal.Elva@state.mn.us

Report #: 7994241141

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health

625 Robert Street North
St Paul

No. of RF/PHI Categories Out	3
No. of Repeat RF/PHI Categories Out	0
Legal Authority MN Rules Chapter 4626	

Date 08/05/24
Time In 11:45:38
Time Out

Minnesota Group Homes Llc	**Address** 6322 Pleasant Avenue South	**City/State** Richfield, MN	**Zip Code** 55423	**Telephone** 6519999616
License/Permit # 0039069	**Permit Holder**	**Purpose of Inspection** Full	**Est Type**	**Risk Category**

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item — Mark "X" in appropriate box for COS and/or R

IN= in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

	Compliance Status					COS	R
Supervision							
1	(IN)	OUT			PIC knowledgeable; duties & oversight		
2	IN	(OUT)	N/A		Certified food protection manager, duties		
Employee Health							
3	(IN)	OUT			Mgmt/Staff;knowledge,responsibilities&reporting		
4	(IN)	OUT			Proper use of reporting, restriction & exclusion		
5	(IN)	OUT			Procedures for responding to vomiting & diarrheal events		
Good Hygenic Practices							
6	(IN)	OUT		N/O	Proper eating, tasting, drinking, or tobacco use		
7	(IN)	OUT		N/O	No discharge from eyes, nose, & mouth		
Preventing Contamination by Hands							
8	(IN)	OUT		N/O	Hands clean & properly washed		
9	IN	OUT	N/A	(N/O)	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10	IN	(OUT)			Adequate handwashing sinks supplied/accessible		
Approved Source							
11	(IN)	OUT			Food obtained from approved source		
12	IN	OUT	N/A	(N/O)	Food received at proper temperature		
13	(IN)	OUT			Food in good condition, safe, & unadulterated		
14	IN	OUT	(N/A)	N/O	Required records available; shellstock tags, parasite destruction		
Protection from Contamination							
15	(IN)	OUT	N/A	N/O	Food separated and protected		
16	(IN)	OUT	N/A		Food contact surfaces: cleaned & sanitized		
17	(IN)	OUT			Proper disposition of returned, previously served, reconditioned, & unsafe food		

	Compliance Status					COS	R
Time/Temperature Control for Safety							
18	IN	OUT	N/A	(N/O)	Proper cooking time & temperature		
19	IN	OUT	(N/A)	N/O	Proper reheating procedures for hot holding		
20	IN	OUT	(N/A)	N/O	Proper cooling time & temperature		
21	IN	OUT	(N/A)	N/O	Proper hot holding temperatures		
22	IN	(OUT)	N/A		Proper cold holding temperatures		
23	(IN)	OUT	N/A	N/O	Proper date marking & disposition		
24	IN	OUT	(N/A)	N/O	Time as a public health control: procedures & records		
Consumer Advisory							
25	IN	OUT	(N/A)		Consumer advisory provided for raw/undercooked food		
Highly Susceptible Populations							
26	IN	OUT	(N/A)		Pasteurized foods used; prohibited foods not offered		
Food and Color Additives and Toxic Substances							
27	IN	OUT	(N/A)		Food additives: approved & properly used		
28	(IN)	OUT			Toxic substances properly identified, stored, & used		
Conformance with Approved Procedures							
29	IN	OUT	(N/A)		Compliance with variance/specialized process/HACCP		

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance — Mark "X" in appropriate box for COS and/or R — **COS=** corrected on-site during inspection **R=** repeat violation

			COS	R
Safe Food and Water				
30	IN OUT (N/A)	Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32	IN OUT (N/A)	Variance obtained for specialized processing methods		
Food Temperature Control				
33		Proper cooling methods used; adequate equipment for temperature control		
34	IN OUT (N/A) N/O	Plant food properly cooked for hot holding		
35	(IN) OUT N/A N/O	Approved thawing methods used		
36		Thermometers provided & accurate		
Food Identification				
37		Food properly labled; original container		
Prevention of Food Contamination				
38		Insects, rodents, & animals not present		
39		Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
Proper Use of Utensils				
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
Utensil Equipment and Vending				
47	X	Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48	X	Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
Physical Facilities				
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 08/05/24

Inspector (Signature) Crystal Elva