DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

July 20, 2022

Administrator
Clinique Healthcare Services Inc
7924 June Avenue North
Brooklyn Park, MN 55444

RE: Project Number(s) SL35377015

Dear Administrator:

On June 27, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine correction of orders found on the evaluation completed on April 19, 2022. This follow-up evaluation determined your facility had not achieved full compliance, as we identified the following new violation(s):

0950-Designation Of Representative-144.50 Subd. 3
0970-Waivers Of Liability Prohibited-144.50 Subd. 5

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

Therefore, as a result of this follow-up evaluation you are in substantial compliance and in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, no immediate fines will be assessed.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), by the correction order date, the licensee must document in the provider's records any action taken to comply with the correction order by the correction order date. The commissioner may request a copy of this documentation and the assisted living facility's action to respond to the correction orders in future evaluations, upon a complaint investigation, and as otherwise needed.

IMPOSITION OF FINES:

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.

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you have one opportunity to challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. This written request must be received by the Department of Health within 15 calendar days of the correction order receipt date. Please send your written request via email to the following:

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

We urge you to review these orders carefully. If you have questions, please contact Jess Gallmeier at 651-247-0268.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Sincerely,

Jess Gallmeier, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jess.gallmeier@state.mn.us
Phone: 651-247-0268 Fax: 651-215-9697

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35377	A. BUILDING: _____ B. WING _____	R 06/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLINIQUE HEALTHCARE SERVICES I	7924 JUNE AVENUE NORTH BROOKLYN PARK, MN 55444

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments 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: Project # SL35377015-1 On June 27, 2022, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on April 19, 2022. At the time of the survey, there were three residents receiving services under the Assisted Living license. As a result of the revisit, the following orders were issued.	{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 Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	{0 480}		

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{0 480}	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (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: No Further action required	{0 480}		
{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	{0 780}		

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{0 780}	Continued From page 2 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: No Further action required	{0 780}		
{0 790} SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: No Further action required	{0 790}		
{0 800} SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment	{0 800}		

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{0 800}	Continued From page 3 (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: No Further action required	{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	{0 810}		

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{0 810}	Continued From page 4 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: No Further action required	{0 810}		
0 950 SS=C	144.50 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	0 950		

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0 950	Continued From page 5 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 ensure the assisted living contract included the designation of representative statutory language for one of one resident (R1) with record reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the client 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 the potential to affect a large portion or all of the residents). The findings include: R1 was admitted on March 1, 2022. R1's Assisted Living Contract signed and dated May 24, 2022, lacked the verbatim "right to designate a representative for certain purposes" notice required at the time of execution of the contract. On June 27, 2022, at approximately 2:00 p.m., registered nurse (RN)-A and licensed assisted living director (LALD)-C acknowledged the required verbatim notice was not included in the resident's contract. They also stated the same contract was used for all the licensee's residents.	0 950		

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0 950	Continued From page 6 The licensee's undated Assisted Living Contracts policy indicated the licensee would include the verbatim "right to designate a representative for certain purposes". No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950		
0 970 SS=C	144.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for the health, safety, or personal property of a resident. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the client 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 the potential to affect a large portion or all of the	0 970		

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0 970	Continued From page 7 residents). The findings include: R1 was admitted on March 1, 2022. R1's Assisted Living Contract signed and dated May 24, 2022, indicated the licensee was not liable for any damage or injury to the resident or any other person or to any property occuring on the licensee's premises. On June 27, 2022, at approximately 2:00 p.m., registered nurse (RN)-A and licensed assisted living director (LALD)-C acknowledged the contract waived the licensee's liability for the health, safety, or personal property of a resident. They also stated the same contract was used for all the licensee's residents. The licensee's undated Assisted Living Contract policy lacked verbiage to include liability waivers. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		
{02040} SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to	{02040}		

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{02040}	Continued From page 8 protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: No Further action required	{02040}		

Electronically Delivered

May 18, 2022

Administrator
Clinique Healthcare Services Inc
7924 June Avenue North
Brooklyn Park, MN 55444

RE: Project Number(s) SL35377015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on April 19, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health 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.

The enclosed State Form documents the state licensing orders. The Department of Health 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 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.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes 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. The Department of Health 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 (a)(5)(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 evaluation:

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

The total amount you are assessed is $3,000.00. You will be invoiced after 15 days of the receipt of this notice, subject to appeal. **OR** Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, no immediate fines are assessed.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction 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 issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the Department of Health within 15 calendar days of the correction order receipt date.

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

Free from Maltreatment reconsideration requests should be addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

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. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

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.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,

Jess Gallmeier, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jess.gallmeier@state.mn.us
Phone: 651-247-0268 Fax: 651-215-9697

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0 000	Initial Comments 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: SL# 35377015 On April 18, 2022 through April 19, 2022, 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 four (4) residents, all of whom recieved servcies under the provider's Assisted Living with Dementia Care license.	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.	
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a	0 250		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 250	Continued From page 1 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; (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 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	0 250		

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	35377	A. BUILDING: _____ B. WING _____	04/19/2022

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0 250	Continued From page 2 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 interview and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required with records reviewed. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on April 18, 2022, at approximately 9:30 a.m., registered nurse (RN)-A and licensed assisted living director (LALD)-C stated the licensee's employees in	0 250		

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0 250	Continued From page 3 charge of the facility were familiar with the assisted living regulations and the licensee provided medication and treatment management services. The licensee's Application for Assisted Living License, section titled Official Verification of Owner or Authorized Agent, (page four and five 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, 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. - I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G. - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659. - Reporting of Maltreatment of Vulnerable Adults. - Electronic Monitoring in Certain Facilities. - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will use information provided in this application, which may include an in-person or telephone	0 250		

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0 250	Continued From page 4 conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license. - I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 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	0 250		

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0 250	Continued From page 5 indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of 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 and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page five was electronically signed by Anthony Ogbonnaya Orjinta on June 7, 2021. The licensee had an assisted living license issued on August 1, 2021, with an expiration date of July 31, 2022. The licensee failed to ensure the following policies and procedures were developed and/or implemented: - requirements in section 626.557, reporting of maltreatment of vulnerable adults; - orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; - conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; - medication and treatment management. On April 19, 2022, at approximately 1:10p.m., RN-A and LALD-C confirmed the licensee provided assisted living with dementia care services but failed to implement corresponding policies and procedures as required.	0 250		

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0 250	Continued From page 6 As a result of this survey, the following orders were issued [0250, 0430, 0480,0485, 0640, 0650, 0660, 0680, 0780, 0790, 0800, 0810, 0900, 1380, 1460, 1620, 1650,1730, 1760, 1770, 1820, 2040, 2110, 2260, 2310, and 3090] indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250		
0 430 SS=F	144G.40 Subd. 2 Uniform checklist disclosure of services (a) All assisted living facilities must provide to prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a).	0 430		

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0 430	Continued From page 7 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a copy of the uniform disclosure of assisted living services (UDALSA) with the required content for two of two residents (R1, R3) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1 admitted to licensee on March 1, 2022. R1's service plan dated March 1, 2022, indicated R1 received services for nursing assessments, assistance with activities of daily living, mobility, tube feeding, wound care, behavior management, activities, and range of motion. R3 R3 admitted to licensee on September 1, 2020. R3's service plan dated September 1, 2020, indicated R3 received services for medication set up, medication administration, housekeeping, meals, nursing, and home health aide. R3's record included a document titled Statement of Home Care Services Comprehensive Home	0 430		

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0 430	Continued From page 8 Care Provider dated September 1, 2020. R1 and R3's record lacked a UDALSA checklist to include: - a disclosure of the categories of assisted living licenses available and the category of license held by the licensee; and - a written checklist listing all services permitted under the licensee's license, identifying all services the licensee offers to provide under the assisted living licensee's contract, and identifying all services allowed under the license that the licensee does not provide. On April 19, 2022, at 9:53 a.m., licensed assisted living director (LALD)-C confirmed R3's record lacked the UDALSA. LALD-C stated the licensee had not converted all paperwork from home care to assisted living. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 430		
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: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply:	0 480		

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0 480	Continued From page 9 (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 according to the Minnesota Food Code. 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, 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: Please refer to the additional documentation included in the Food and Beverage Establishment Inspection Reports, dated April 18, 2022. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 485 SS=C	144G.41 Subd 1. (13) (i) (A) and (C) Minimum Requirements (13) offer to provide or make available at least the following services to residents:	0 485		

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0 485	Continued From page 10 (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (A) menus must be prepared at least one week in advance, and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; (C) the facility cannot require a resident to include and pay for meals in their contract; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to have a menu prepared at least one week in advance and made available to all residents. This had the potential to affect all four (4) residents of the facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On April 18, 2022, at approximately 10:20 a.m., the surveyor observed the menu plan on the	0 485		

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0 485	Continued From page 11 bulletin board. The observed menu was not prepared at least one week in advance and lacked the date meals were to be served. On April 18, 2022, at 10:22 a.m., licensed assisted living director (LALD)-C acknowledged the menu was not prepared at least one week in advance. LALD-C stated the licensee was unaware of the requirement. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to support protection and safety by not posting information and reporting number for the Minnesota Adult Abuse Reporting Center (MAARC) in a common area.	0 640		

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0 640	Continued From page 12 This had the potential to affect all four (4) 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 April 18, 2022, at approximately 10:18 a.m., the surveyor observed no posted information and reporting number for MAARC on the licensee's communication board or elsewhere in the split entry level building. Resident binder records reviewed lacked information and reporting number for MAARC. On April 18, 2022, at 10:45 a.m., registered nurse (RN)-A confirmed a post of information and the reporting number for MAARC was not present. RN-A stated the licensee provided binders to the residents with information and reporting number of MAARC. The licensee's undated Reporting Maltreatment of Vulnerable Adult policy indicated the licensee would post information and the reporting number for MAARC to report suspected maltreatment of a vulnerable adult under section 626.557. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	0 640		

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0 640	Continued From page 13 days	0 640		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on interview and record review, the	0 650		

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0 650	Continued From page 14 licensee failed to ensure employee records included all required content for one of two employees (registered nurse (RN)-A) with employee records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: RN-A started employment on June 22, 2008, under the comprehensive home care license and began providing assisted living services on August 1, 2021. RN-A's employee record contained an annual performance review dated January 18, 2021. RN-A's employee record lacked annual performance reviews for other years of employment with the licensee. On April 18, 2022, at approximately 12:20 p.m., RN-A stated the licensee had additional performance evaluations, however, they were located at a different location. The surveyor did not receive additional information from licensee on RN-A's performance evaluations. The licensee's undated Employee Records policy indicated the licensee would maintain current records of each paid employees' annual performance reviews that identified areas of improvement needed and training needs.	0 650		

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0 650	Continued From page 15 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC). In addition, the licensee failed to ensure employees completed TB training for one of two employees (registered nurse (RN)-A) with employee records reviewed. This had the potential to affect all four (4) residents, staff, and visitors.	0 660		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLINIQUE HEALTHCARE SERVICES I	7924 JUNE AVENUE NORTH BROOKLYN PARK, MN 55444

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 660	Continued From page 16 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: The licensee's TB risk assessment dated February 26, 2021, indicated the licensee was a low risk setting for TB transmission. RN-A started employment on June 22, 2008, under the comprehensive home care license and began providing assisted living services on August 1, 2021. RN-A record lacked evidence of completed TB training as required. On April 18, 2022, at approximately 12:20 p.m., RN-A stated they thought TB training was covered under infection control. The surveyor requested to see the contents of class. On April 19, 2022, at 10:27 a.m., RN-A stated she was unable to find the contents of the infection control class. The licensee's undated Tuberculosis Prevention and Control policy indicated employees would receive training and information on signs and symptoms of TB, health screening and therapy, licensee specific protocols and use of respiratory protection equipment.	0 660		

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0 660	Continued From page 17 The CDC's TB Infection Control in Health Care Setting dated May 14, 2019, recommended educating, training, and counseling health care personnel about TB infection, TB disease, and respiratory protection. 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 tenant 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	0 680		

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0 680	Continued From page 18 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 with all the required content. This had the potential to impact all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's emergency plan contained names of executive officers, an organizational chart, and multiple policy and procedures related to emergency crisis, evacuation, fire, severe weather, shelter in place, CPR, elopement, bomb threat, stranger in building, utility emergencies, and employee incident. The licensee's plan lacked the following required content: -current, all-hazards approach facility assessment; -description of the population served by licensee; -subsistence needs for staff and residents during emergency situation; -procedure for tracking staff and residents; -development of policies/procedures, based on assessment; and additional policies for: -evacuation;	0 680		

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0 680	Continued From page 19 -handling medical documents; and -handling and use of volunteers; -address roles under a waiver declared by secretary in accordance with section 1135 of the Act; -development of a communication plan, including primary and alternate means for communication; -methods for sharing information; -EP training and testing program; -EP training program for staff (including documentation of training provided); and -annual EP testing requirements. On Aril 18, 2022, at 11:42 a.m., registered nurse (RN)-A acknowledged the missing content listed above. RN-A stated the licensee was unaware of all the requirements. In addition, RN-A stated the licensee would review the appendix z requirements and update the licensee's emergency plan. The licensee's undated Emergency Management, Hazard Vulnerability Analysis, Emergency Disaster Plan Orientation and Training, Emergency Preparedness Evacuation, Fire Safety program for the Workplace, Weather Related and Natural Disasters, and Communication Plan for Emergency Preparedness policies, indicated the licensee would have the above content. No additional 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	0 780		

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0 780	Continued From page 20 (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide interconnected smoke alarms as required by Minnesota Statutes, 144G.45, Subd. 2. This has the potential to directly affect staff, visitors, and residents receiving assisted living care. 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	0 780		

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0 780	Continued From page 21 or has the potential to affect a large portion or all of the residents). The findings include: On April 19, 2022, approximately from 10:15 a.m. to 11:30 a.m., survey staff toured the home with the licensed assisted living director (LALD)-C. The home consisted of a two-level split, the upper and lower walkout level, with a total of five bedrooms (#1, #2, #3, #5, and #6) with four currently occupied. The LALD-C explained that Room #4 was not used as a bedroom but as an office. Three resident bedrooms were located on the upper floor with the two bedrooms located on the lower level. On April 19, 2022, approximately from 10:15 a.m. to 10:45 a.m., survey staff toured the home with the LALD-C, about required smoke alarms. -The smoke alarms inside resident bedrooms #1, #2, #3, #5, and #6 were tested and all smoke alarms sounded local. The LALD-C confirmed the findings as he explained that all smoke alarms in the bedrooms are battery-operated and only sound locally. -The smoke alarms in the hallways of the upper and lower floor were tested and sounded local. The LALD-C explained that the smoke alarm in the hallway on the upper-level floor was hardwired. Survey staff explained to the LALD-C that the smoke alarms in the home must all be interconnected such that when one smoke alarm sounds, all smoke alarms in the home must sound throughout for notification. The interconnection of smoke alarms applies to all	0 780		

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0 780	Continued From page 22 smoke alarms in the bedrooms and hallways. The findings were verified by the LALD-C as he asked about the interconnection of battery-operated smoke alarms available. Survey staff recommended that the LALD-C consult with a professional or the manufacturer of their existing hardwired smoke alarms were wired properly in the hallway and to ensure the new battery-operated smoke alarms will be capable for interconnection with the hardwired smoke alarms. The improper interconnection of smoke alarms prevent the early notification of fire for the residents which can delay the response time of the evacuation of the entire home. On April 19, 2022, at approximately 12:30 p.m., the LALD-C acknowledged the findings during the exit interview. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	0 780		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire	0 790		

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0 790	Continued From page 23 Code; and This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to maintain the required portable fire extinguishers in accordance with the State Fire Code as required by MN Statute 144G.45 Subd(a)(2). 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, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On April 19, 2022, approximately from 10:15 a.m. to 11:30 a.m., survey staff toured the home with the licensed assisted living director (LALD)-C. At approximately 11:10 a.m., survey staff toured the facility with the LALD-C about the required portable fire extinguishers. The portable fire extinguishers were observed with the rated type label of 1-A:10-B:C. The minimum rated type must be 2-A:10-B:C. It was also observed that the portable fire extinguishers were not mounted and secured as required, and lacked records to show the required annual service and monthly inspections. These findings were verified with the LALD-C.	0 790		

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0 790	Continued From page 24 On April 19, 2022, at approximately 12:30 p.m., the LALD-C acknowledged the findings during the exit interview. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment of the facility in a continuous state of good repair and operation. This has the potential to directly affect the health, safety, and well-being of all residents, visitors, 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:	0 800		

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0 800	Continued From page 25 On April 19, 2022, approximately from 10:15 a.m. to 11:30 a.m., survey staff toured the home with the licensed assisted living director (LALD)-C, and observed the following during the tour: -The furnace filter was heavily layered with thick dust and was missing a cover over the filter compartment. -The window handle and hardware arm utilized to open the window for bedroom #6 was not fully operational. Bedroom egress windows must operate freely and easily opened by assisted living residents. -The window in resident room # 5 failed to open when the LALD-C attempted to open it. Survey staff also observed that the window had a hook on the upper trim of the window to lock it. Survey staff explained to the LALD-C that egress windows are not permitted to be locked against egress and must be fully operational and easily opened. The LALD-C stated that the previous resident in the room was a memory care resident, but currently, the home curently does not have any memory care residents. -The transition between the flooring joining the dining room and the kitchen did not provide a smooth floor transition for wheelchair residents to access the deck. This also posed a potential tripping hazard for residents and staff. -The electric panel was not accessible and was blocked with chemicals and storage boxes. -The gate used for entrance and exit from the yard was not fully operable or easy to use when opened and closed due to gravel rocks under the gate. Survey staff explained to the LALD-C that if this gate is used as an exit for accessible residents, it must be freely opened and fully operable.	0 800		

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0 800	Continued From page 26 On April 19, 2022, at approximately 12:30 p.m., the LALD-C acknowledged the findings during the exit interview. Survey staff explained to the LALD-C that bedroom windows may only be secured from elopment when approved by the authorities due to the clinical needs of residents such elopement prevention for memory care residents, and when the home has an approved fire suppression system, which the home does not. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility.	0 810		

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0 810	Continued From page 27 (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on document review and interview, the licensee failed to provide the required content of documentation on the fire safety plan, employee training, and employee evacuation drills. This has the potential to directly affect the safety of visitors, staff, and all residents receiving assisted living care. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On April 19, at approximately 11:30 a.m., survey staff asked for the home's fire safety and evacuation plan, training, and drill documentation. The review of the documentation provided by the licensed assisted living director (LALD)-C	0 810		

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0 810	Continued From page 28 indicated the following: FIRE SAFETY AND EVACUATION PLAN Plan documentation lacked documentation of fire protection procedures for residents. FIRE AND EVACUATION DRILLS The licensee failed to perform the minimum number of drills required by employees twice per year per shift, with at least one evacuation drill every other month. Record review indicated the number of drills performed and recorded were November 2, 2021, January 15, 2022, March 12, 2022 (dated but not filled out completely), and with the City of Brooklyn Center Fire Department dated August 8, 2019. TRAINING -The licensee failed to provide the policy documentation and record of employee training on the fire safety and evacuation plan. The minimum required employee training is upon hire and twice a year. -The licensee failed to provide documentation to show training of residents that can self-assist in their evacuation during on the proper actions to be taken in the event of a fire including movement, evacuation, or relocation. On April 19, 2022, at approximately 12:30 p.m., the LALD-C acknowledged the findings during the exit interview. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 810		

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0 900	Continued From page 29	0 900		
0 900 SS=F	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed.	0 900		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLINIQUE HEALTHCARE SERVICES I	7924 JUNE AVENUE NORTH BROOKLYN PARK, MN 55444

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0 900	Continued From page 30 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and execute an assisted living written contract with the required content for two of two residents (R1, R3) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 admitted to the licensee on September 20, 2020. R3 admitted to the licensee on March 3, 2022. R1 and R3's records lacked a written contract which included all of the terms concerning the provisions of the following as required: - housing; - assisted living services, whether provided directly by the licensee or by management agreement or other agreement; and - the resident's service plan, if applicable. In addition, R1 and R3's records lacked evidence that the contract had been fully executed as the licensee must: - offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract;	0 900		

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0 900	Continued From page 31 - give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed; and - the licensee must offer the resident the opportunity to identify a designated representative. On April 19, 2022, at 9:53 a.m., licensed assisted living director (LALD)-C confirmed R1 and R3's records lacked an assisted living contract. LALD-D stated licensee is currently working on creating a contract and residents in the licensee's facility had not received an assisted living contract. The licensee's undated Assisted Living Contracts policy indicated the licensee would establish a contract with each resident at the time of admission that would be inclusive of both the tenant-landlord relationship and the services to be provided. In addition, the resident and Office of the Ombudsman for Long-Term Care would receive a copy of contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 900		
01380 SS=D	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;	01380		

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01380	Continued From page 32 (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 interview and record review, the licensee failed to ensure training was completed in all required areas for one of two employees (unlicensed personnel (ULP)-B) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-B started employment on March 1, 2022, and began providing assisted living services. ULP-B's employee file lacked documentation of competency evaluations for the following topics: - reading and recording temperature, pulse, and respirations of the resident; and -range of motioning and positioning.	01380		

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01380	Continued From page 33 On April 18, 2022, at approximately 1:20 p.m., registered nurse (RN)-A stated the training content listed above may be located in a different location and the licensee would look for them. On April 19, 2022, at 10:27 a.m., the surveyor received multiple documents from RN-A on ULP-B's trainings. The documents lacked the content above. The licensee's undated Competency Evaluations policy indicated the licensee would implement and provide a competency evaluation program that meets minimum standards in accordance with state guidelines. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01380		
01460 SS=F	144G.63 Subdivision 1 Orientation of staff and supervisors All staff 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 may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received	01460		

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01460	Continued From page 34 orientation to 144G licensing requirements for two of two employees (registered nurse (RN)-A, unlicensed personnel (ULP)-B) with employee records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on April 18, 2022, at approximately 9:30 a.m., RN-A and licensed assisted living director (LALD)-C stated they were aware of the required content in the employee records. RN-A RN-A started employment on June 22, 2008, under the comprehensive home care license and began providing assisted living services on August 1, 2021. RN-A's employee record lacked evidence RN-A received orientation to the following required topics: - an overview of this chapter; - an introduction and review of the licensee's policies and procedures related to the provision of assisted living services; - handling of emergencies and use of emergency services; - compliance with and reporting of the maltreatment of vulnerable adults under section	01460		

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01460	Continued From page 35 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); - the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; - 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; - a review of the types of assisted living services the employee will be providing and the licensee's category of licensure; and - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. ULP-B ULP-B started employment on March 1, 2022, and began providing assisted living services. ULP-B's employee record lacked evidence of orientation to the following requirements as part of the orientation to assisted living: - an overview of this chapter; - an introduction and review of the licensee's policies and procedures related to the provision of assisted living services; - the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; - a review of the types of assisted living services the employee will be providing and the licensee's category of licensure; and - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person.	01460		

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01460	Continued From page 36 On April 18, 2022, at 11:42 a.m., RN-A confirmed employee records lacked the content listed above. RN-A stated they thought they had until August of 2022 to complete the above content. In addition, RN-A stated they had signed up for a class to complete the above content that will occur in May 2022. The licensee's undated Facility Employee Orientation policy indicated employees would complete an orientation with the content listed above and orientation training would be documented and kept in the employee personnel file. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01460		
01620 SS=D	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 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	01620		

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01620	Continued From page 37 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) conduct ongoing client monitoring and reassessment, not to exceed 14 calendar days from the first date of the initial assessment was completed for one of two residents (R1) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client'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 clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted to the licensee on March 3, 2022. R1's Service Plan dated March 1, 2022, indicated R1 received services including nursing assessments, assistance with activities of daily living, mobility, tube feeding, wound care, behavior management, activities and functional maintenance.	01620		

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01620	Continued From page 38 R1's initial comprehensive assessment dated March 1, 2022, contained all the required parts of the uniform assessment tool. On April 18, 2022, at approximately 11:30 a.m., RN-A acknowledged R1's record was missing a 14-day assessment after the initial assessment was completed, and stated it was an oversight, but the licensee had plans in place to avoid such an occurrence again. The licensee's undated Nursing Assessment and Reassessment of Residents policy indicated residents' reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01650 SS=E	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service	01650		

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01650	Continued From page 39 cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan contained all the required content for two of two residents (R1, R3) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 R1 admitted to the licensee on March 3, 2022. R1's Service Plan dated March 1, 2022, indicated	01650		

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01650	Continued From page 40 R1 received services including nursing assessments, assistance with activities of daily living, mobility, tube feeding, wound care, behavior management, activities and functional maintenance. R1's service plan lacked the following content: - a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; - the methods of monitoring assessments of the resident; - the schedule and methods of monitoring staff providing services; and - a contingency plan that includes: - the action to be taken if the scheduled service cannot be provided; and - information and a method to contact the licensee. R3 R3 admitted to the licensee on September 20, 2020. R3's Service Plan dated September 1, 2020, indicated R3 received services including home health aide, nursing, medication set up, medication administration, housekeeping, meals, and treatments. R1's service plan lacked the following content: - the identification of staff or categories of staff who will provide the services; - the schedule and methods of monitoring assessments of the resident; and - the schedule and methods of monitoring staff providing services. On April 18, 2022, at approximately 12:30 p.m., registered nurse (RN)-A stated the licensee was not aware of the missing content in the service	01650		

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01650	Continued From page 41 plan. The licensee's undated Service Plan policy indicated the licensee's service plans would contain the content listed above. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered	01730		

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01730	Continued From page 42 nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an individualized medication management plan with the required content for one of one resident (R1) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: On April 19, 2022, at approximately 8:20 a.m., ULP-D administered R1's morning medications via gastrostomy tube (G-tube).	01730		

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01730	Continued From page 43 R1's service plan dated March 1, 2022, indicated R1 received services to include comprehensive assessment, assistance with activities of daily living, tube feeding, wound care, and behavioral health. R1's Medication Administration Log dated March 1, 2022, indicated R1 received medications to include: -seroquel 25 milligram (mg) one tablet via G-tube -valproic acid 250 mg/5 milliliter (ml) G-tube three times a day -vitamin B-12 1000 microgram (mcg) one tablet G-tube -lisinopril 20 mg one tablet G-tube -sertraline hcl 100 mg one tablet G-tube -aspirin 81 mg one tablet G-tube -phenobarbital 64.8 mg one tablet G-tube -hydroxychloroquine 200 mg one tablet G-tube two times daily -metoprolol tartrate 25 mg one tablet G-tube two times daily -haloperidol lac 2 mg/ml G-tube three times daily R1's individual medication management record lacked the content to include: -a statement describing the medication management services that will be provided; -documentation of specific resident instructions relating to the administration of medications; -identification of medication management tasks that may be delegated to unlicensed personnel; and -procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services. On April 19, 2022, at approximately 10:20 a.m.,	01730		

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CLINIQUE HEALTHCARE SERVICES I	7924 JUNE AVENUE NORTH BROOKLYN PARK, MN 55444

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01730	Continued From page 44 registered nurse (RN)-A acknowledged R1's medication management record lacked the required content and stated the licensee will update the records to reflect the required content. The licensee's undated Individualized Medication Management Plan and Record policy indicated all the missing content noted above will be included in the records. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the documentation included the signature and title of the person who administered the medication for	01760		

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01760	Continued From page 45 one of one resident (R1) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: On April 19, 2022, at approximately 8:30 a.m., ULP-D administered R1's morning medications via gastrostomy tube (G-tube). R1' service plan dated March 1, 2022, indicate R1 received services to include comprehensive assessment, assistance with activities of daily living, tube feeding, wound care, and behavioral health. R1's Medication Administration Log dated March 1, 2022, indicated R1 received medications to include: -seroquel 25 milligram (mg) one tablet via G-tube -valproic acid 250 mg/5 milliliter (ml) G-tube three times a day -vitamin B-12 1000 microgram (mcg) one tablet G-tube -lisinopril 20 mg one tablet G-tube -sertraline hcl 100 mg one tablet G-tube -aspirin 81 mg one tablet G-tube -phenobarbital 64.8 mg one tablet G-tube -hydroxychloroquine 200 mg one tablet G-tube two times daily -metoprolol tartrate 25 mg one tablet G-tube two times daily	01760		

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01760	Continued From page 46 -haloperidol lac 2 mg/ml G-tube three times daily On April 19, 2022, at approximately 11:35 a.m., registered nurse (RN)-A acknowledged R1's Medication Administration Log lacked documentation including the signature and title of the person who administered the medication. RN-A also stated she had introduced a sign off sheet with unlicensed personnel's names and titles to be included as a front page for all residents' Medication Administration Log. The licensee's undated Medication Management Services policy indicated the RN will ensure that unlicensed personnel are trained competent to perform medication management services. The policy lacked the verbiage to include signatures and titles of the person who administered the medication. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01770 SS=D	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure documentation of medication setup included all	01770		

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01770	Continued From page 47 the required content for one of one resident (R1) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on April 18, 2022, at approximately 9:45 a.m., registered nurse (RN)-A stated the licensee provided medication management services which included medication setup by the RN for residents. On April 19, 2022, at approximately 8:10 a.m., unlicensed personnel (ULP)-D dispensed medications to R1 from a pill box, crushed them, then administered through a gastrostomy tube (G-tube). R1's record lacked medication setup record to include name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup. On April 19, 2022, at approximately 9:30 a.m., RN-A acknowledged the medication setup record lacked the required content as noted above. The licensee's undated Medication Setup policy indicated the licensee will setup medications for residents as ordered by the prescriber and	01770		

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01770	Continued From page 48 document compliance in taking medications as setup by nurse. The policy lacked the verbiage to include the setup content noted above. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770		
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure written or electronically recorded prescriptions were obtained for one of one resident (R1) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: On April 19, 2022, at approximately 8:30 a.m., ULP-D administered R1's morning medications	01820		

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01820	Continued From page 49 via gastrostomy tube (G-tube). R1's service plan dated March 1, 2022, indicated R1 received services to include comprehensive assessment, assistance with activities of daily living, tube feeding, wound care, and behavioral health. R1's Medication Administration Log dated March 1, 2022, indicated R1 received medications to include: -seroquel 25 milligram (mg) one tablet via G-tube -valproic acid 250 mg/5 milliliter (ml) G-tube three times a day -vitamin B-12 1000 microgram (mcg) one tablet G-tube -lisinopril 20 mg one tablet G-tube -sertraline hcl 100 mg one tablet G-tube -aspirin 81 mg one tablet G-tube -phenobarbital 64.8 mg one tablet G-tube -hydroxychloroquine 200 mg one tablet G-tube two times daily -metoprolol tartrate 25 mg one tablet G-tube two times daily -haloperidol lac 2 mg/ml G-tube three times daily On April 19, 2022, at approximately 10:30 a.m., registered nurse (RN)-A provided copies of prescriptions from the pharmacy, but they lacked a prescriber's signature. On April 19, 2022, at approximately 10:40 a.m., RN-A acknowledged the licensee did not have physician signed orders for R1's medications. RN-A also stated the licensee was convinced the pharmacy could not supply medications if they did not have a physician order. No further information was provided.	01820		

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01820	Continued From page 50 TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on observation, document review, and interview, the licensee failed to provide a complete facility hazard vulnerability or safety risk assessment (HVA) plan to identify hazard vulnerabilities and mitigation on and around the property. In addition, the hazards identified on the HVA plan must be mitigated to protect the memory care residents from harm. This has the potential to directly affect memory care resident(s) receiving assisted living services and staff. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when	02040		

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02040	Continued From page 51 problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the clients). The findings include: On April 19, 2022, approximately from 10:15 a.m. to 11:30 a.m., survey staff toured the home with the licensed assisted living director (LALD)-C. Survey staff asked about their licensure for memory care residents. The LALD-C explained that they currently have four residents and no memory care residents in the home. On April 19, 2022, at approximately 11:30 a.m., survey staff received the home's HVA documentation (undated) for review: -The HVA plan documentation outlined hazard assessment for hurricane, flooding, civil unrest, etc., but lacked specific hazard content associated with the home and its surrounding property to protect the memory care residents from those harm. Resident elopement from doors and windows, potential risks of the accessing stove, oven, dishwashers, and sharp tools/knives in the kitchen, potential risk of accessing chemicals, the risk of the misuse of portable fire extinguishers, and nearby highways and ponds that may pose a hazard vulnerability to a memory care resident. These hazard vulnerabilities need to be assessed and mitigated in the plan. - The HVA plan documentation lacked identifying mitigation associated with hazard vulnerabilities. Mitigation may be monitoring equipment and training provided to protect all memory care residents from potential harm. On April 19, 2022, at approximately 12:30 p.m., survey staff discussed the findings on the HVA	02040		

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02040	Continued From page 52 plan and explained to the LALD-C that hazards associated with the home and around the property must be identified, assessed, and mitigated. Both hazard vulnerabilities and mitigation must be documented in the HVA plan and implemented to protect memory care residents from potential harm. The LALD-C acknowledged the findings at the exit interview. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	02040		
02110 SS=F	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and	02110		

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02110	Continued From page 53 how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure policies and procedures for assisted living with dementia care were provided to residents and the residents legal and designated representatives at the time of move-in for one of one resident (R1) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 April 19, 2022, at approximately 8:30 a.m., ULP-D administered R1's morning medications via gastrostomy tube. R1 was admitted to the assisted living facility with	02110		

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02110	Continued From page 54 dementia care on March 1, 2022. R1' service plan dated March 1, 2022, indicated R1 received services to include comprehensive assessment, assistance with activities of daily living, tube feeding, wound care, and behavioral health. R1's record lacked policies and procedures that address the: -Philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; -Evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; -Wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; -Medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; -Staff training specific to dementia care; -Description of life enrichment programs and how activities are implemented; -Description of family support programs and efforts to keep the family engaged; -Limiting the use of public address and intercom systems for emergencies and evacuation drills only; -Transportation coordination and assistance to and from outside medical appointments; and -Safekeeping of residents' possessions. On April 19, 2022, at approximately 10:10 a.m., registered nurse (RN)-A acknowledged the licensee had not developed and implemented	02110		

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02110	Continued From page 55 policies and procedures that address the above areas. RN-A also stated none of the licensee's residents had received the policies on admission. The licensee's undated Training Requirements for Assisted Living Facilities With Dementia Care policy lacked the verbiage to include the required policies and procedures. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02110		
02260 SS=C	144G.90 Subd. 3 Notice of dementia training An assisted living facility with dementia care shall make available in written or electronic form, to residents and families or other persons who request it, a description of the training program and related training it provides, including the categories of employees trained, the frequency of training, and the basic topics covered. A hard copy of this notice must be provided upon request. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide in written or electronic form to residents, families, or other persons who request it, a description of the dementia care training program, the categories of employees trained, the frequency of training, and the basic topics covered with records reviewed. 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	02260		

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02260	Continued From page 56 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 the potential to affect a large portion or all the residents). The findings include: On August 1, 2021, the licensee started providing services as an assisted living facility with dementia care. On April 18, 2022, at approximately 10:10 a.m., during the entrance conference, the surveyor requested for the description of the dementia training program and related training the licensee provided. On April 19, 2022, at approximately 11:15 a.m., registered nurse (RN)-A acknowledged the licensee lacked a description of the dementia care training program, the categories of employees trained, the frequency of training, and the basic topics covered. RN-A stated all the licensee's dementia training was done in Educare software. The licensee's undated Dementia Care Training policy indicated the licensee provides dementia training to all direct care staff and their supervisors and will make appropriate disclosures to residents and resident representatives who request the information. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02260		

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02310	Continued From page 57	02310		
02310 SS=G	144G.91 Subd. 4 Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care standards, medical or nursing standards with bed rails for one of two residents (R3) with records reviewed. 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 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: On April 19, 2022, at approximately 8:28 a.m., R3 was in his bed. R3's bed was equipped with bilateral side rails. The rails were approximately three feet wide by one and one-half feet in height. The rail mid-section had four vertical bars (about 1 1/2 feet in height) and were flanked by two additional vertical bars and each side, which were about one foot in height. There were eight vertical bars in total, each spaced about four inches apart. The rails could be raised and lowered. The bedrails were firmly fastened to the bed frame on	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35377	A. BUILDING: _____ B. WING _____	04/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLINIQUE HEALTHCARE SERVICES I	7924 JUNE AVENUE NORTH BROOKLYN PARK, MN 55444

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 58 grasp. R3 had an admission date of September 20, 2020. R3's diagnoses included dementia with behavioral disturbance, delusional disorder, and major neurocognitive disorder. R3's Physical Device Evaluation dated November 3, 2021, indicated R3 had weakness, frequent falls, had difficulty getting in and out bed and repositioning. R3's evaluation also indicated the bedrail was used for mobility, positioning, and personal preference. R3's record lacked evidence the licensee had completed bed rails measurements, in addition R3's record lacked evidence an explanation of the risk verses benefits of the use of bed rails had been completed and provided to the resident or the resident's representative. On April 19, 2022, at approximately 8:40 a.m., registered nurse (RN)-A acknowledged the residents or the residents' representative had discussed and been provided with risks verses benefits of the use of bedrails. RN-A also stated because they had completed assessment that was all they needed. The Food and Drug Administration (FDA), "A Guide to Bed Safety," revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35377	A. BUILDING: _____ B. WING _____	04/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLINIQUE HEALTHCARE SERVICES I	7924 JUNE AVENUE NORTH BROOKLYN PARK, MN 55444

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 59 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 licensee's undated Use of Side Rails policy indicated the registered nurse will educate the resident and resident representative about the risks related to side rails and will assess whether the side rails meet FDA standards. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	02310		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors Subd. 8.Notice to visitors. (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the required notice was posted at the main entry way of the establishment to display statutory language to disclose electronic monitoring activity. This had the potential to affect all four (4) residents, staff and any visitors of the licensee.	03090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35377	A. BUILDING: _____ B. WING _____	04/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLINIQUE HEALTHCARE SERVICES I	7924 JUNE AVENUE NORTH BROOKLYN PARK, MN 55444

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
03090	Continued From page 60 This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On April 18, 2022, at approximately 9:30 a.m., upon arriving at the establishment, the surveyor did not observe outside the front entrance, or just inside the front entrance, the required posting for electronic monitoring devices. On April 18, 2022, at approximately 10:40 a.m., during a facility tour, the surveyor observed on the main floor, kitchen, and family room in the basement of the split-level single-family home cameras mounted on the walls. On March 18, 2022, at approximately 12:45 p.m., registered nurse (RN)-A confirmed the electronic monitoring notice was not posted. RN-A stated the licensee thought posting was only required if cameras were located outside on establishment's grounds. In addition, RN-A stated residents are made aware of camera use inside the licensee's facility during admission process. The licensee's Electronic Monitoring policy dated January 1, 2020, indicated the licensee will comply with the Minnesota electronic monitoring law and residents or resident representative may conduct electronic monitoring in resident room with consent and notification. No further information provided.	03090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35377	A. BUILDING: _____ B. WING _____	04/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLINIQUE HEALTHCARE SERVICES I	**7924 JUNE AVENUE NORTH BROOKLYN PARK, MN 55444**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
03090	Continued From page 61 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090		

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

Type: Full
Date: *04/18/22*
Time: 12:18:50
Report: 8058221066

Food and Beverage Establishment Inspection Report

Location:
Clinique Healthcare Services I
7924 June Avenue North
Brooklyn Park, MN55444
Hennepin County, 27

Establishment Info:
ID #: 0039148
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7635034757
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.

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

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

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

RAW EGGS STORED ABOVE RTE FOODS - CORRECTED ON SITE

Corrected on Site

Food and Equipment Temperatures

Process/Item: CHICKEN SALAD
Temperature: 36 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

Process/Item: LETTUCE
Temperature: 41 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

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

ESTABLISHMENT IS A SMALL SIZED FACILITY SET IN A RESIDENTIAL NEIGHBORHOOD

APPLIANCES AND FINISHES ARE RESIDENTIAL AND IN GOOD CONDITION

HRD INSPECTOR ASHLEY CREWS
ESTABLISHMENT REPRESENTATIVE: ANTHONY ORJINTA

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 8058221066 of 04/18/22.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Signed:_____
Establishment Representative

Signed:_____
Inspector Number 8058
Sanitarian 3
MDH Metro Office
651 201 4500
health.foodlodging@state.mn.us