



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

February 9, 2024

Licensee

Olydia Home Care Inc

7243 Morgan Avenue North

Brooklyn Center, MN 55430

RE: Project Number(s) SL34307015

Dear Licensee:

On January 24, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the November 30, 2023, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink that reads 'Casey DeVries'.

Casey DeVries, Supervisor

State Evaluation Team

Email: casey.devries@state.mn.us

Telephone: 651-201-5917 Fax: 1-866-890-9290

HHH



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

December 28, 2023

Licensee

Olydia Home Care, Inc.

7243 Morgan Avenue North

Brooklyn Center, MN 55430

RE: Project Number(s) SL34307015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on November 30, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement.

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;

Level 3: a fine of \$3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.

Level 4: a fine of \$5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5), the MDH may impose fine amounts of either \$1,000 or \$5,000 to licensees who are found to be responsible for maltreatment.

The MDH may impose a fine of \$1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The MDH

An equal opportunity employer.

Letter ID: IS7N REVISED

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

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

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

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program = \$500.00

St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services = \$3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$3,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRD-Appeals-Form>

REQUESTING A HEARING

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

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

<https://forms.web.health.state.mn.us/form/HRD-Appeals-Form>.

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

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

If you have any questions, please contact me.

Sincerely,

A handwritten signature in black ink, reading "Casey DeVries". The signature is fluid and cursive, with the first name "Casey" and last name "DeVries" clearly distinguishable.

Casey DeVries, Supervisor

State Evaluation Team

Email: casey.devries@state.mn.us

Telephone: 651-201-5917 Fax: 1-866-890-9290

PMB

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34307	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/30/2023
NAME OF PROVIDER OR SUPPLIER OLYDIA HOME CARE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 7243 MORGAN AVENUE NORTH BROOKLYN CENTER, MN 55430		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL34307015-0 On November 27, 2023, through November 30, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were three (3) active residents receiving services under the Assisted Living license. An immediate correction order was identified on November 30, 2023, issued for SL34307015-0, tag identification 2310. On December 1, 2023, the immediacy of correction order 2310 was removed, however non-compliance remained, and the scope and level remained unchanged.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 250 SS=F	144G.20 Subdivision 1 Conditions	0 250		

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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

Minnesota Department of Health

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0 250	Continued From page 2 facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on 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; and implemented current policies and procedures as required. 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: On November 7, 2023, at approximately 9:50	0 250			

Minnesota Department of Health

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0 250	Continued From page 3 a.m., licensed assisted living director (LALD)-B stated the licensee's employees in 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	0 250			

Minnesota Department of Health

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0 250	Continued From page 4 may include an in-person or telephone 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	0 250			

Minnesota Department of Health

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0 250	Continued From page 5 attachments and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify the 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 six was electronically signed by LALD-B on November 29, 2022. The licensee had an assisted living license issued on March 1, 2023, with an expiration date of February 29, 2024. On November 28, 2023, at 1:10 p.m., LALD-B stated she was not very good at assisted living facility documentation as CNS-A but was pro in bed side cares. As a result of this survey, the following orders were issued: 0250, 0470, 0480, 0485, 0490, 0510, 0640, 0660, 0680, 0720, 0780, 0790, 0800, 0810, 0910, 0970, 1620, 1650, 1730, 1770, 1820, 1880, 1890, 1940, 1960, 1970, 2310, and 3090. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 250			
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements	0 470			

Minnesota Department of Health

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0 470	Continued From page 6 (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a staffing plan to determine staffing levels to meet the needs of all residents. In addition, licensee failed to ensure the required 24-hour staffing schedule was posted in a central location. This had the potential to affect all residents, staff, and visitors.	0 470			

Minnesota Department of Health

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0 470	Continued From page 7 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On November 27, 2023, at 10:10 a.m., during the entrance conference, clinical nursing supervisor (CNS)-A stated the licensee had a staffing plan that was evaluated two times per year. In addition, CNS-A stated the licensee's staffing plan included two staff for day and evening shifts, and one staff for night shift to care for the residents. On November 27, 2023, at 12:30 p.m., during the facility tour the surveyor did not observe a 24-hour staffing schedule posted in a central location. The licensee's Staffing Plan document reflected the plan to be current as of January 9, 2023. The Staffing Plan indicated two twelve (12) hour shifts daily and did not indicate number of staff per shift. On November 30, 2023, at 12:30 p.m., CNS-A stated the staffing schedule was posted in an online communication portal available to staff and residents and they were unaware that a 24-hour staffing schedule was to be posted in a central location. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	0 470			

Minnesota Department of Health

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0 470	Continued From page 8 days	0 470			
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated November 27, 2023, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			
0 485 SS=C	144G.41 Subdivision 1. (13)(i)(A)and(C) Minimum Requirements (13) offer to provide or make available at least the	0 485			

Minnesota Department of Health

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0 485	Continued From page 9 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: (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; and (C) the facility cannot require a resident to include and pay for meals in their contract; (ii) weekly housekeeping; (iii) weekly laundry service; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a menu was prepared a week in advance and provided to the residents. This had the potential to affect all three residents who received services. 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 the potential to affect a large portion or all the residents). The findings include: On November 27, 2023, at 11:30 a.m., the surveyor did not observe a posted menu for the	0 485			

Minnesota Department of Health

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0 485	Continued From page 10 residents. On November 28, 2023, at 8:15 a.m., R3 stated licensee had not provided him with a meal menu. R3 also stated staff did not consider asking his meal preference most of the time. On November 30, 2023, at 11:44 a.m., clinical nurse supervisor (CNS)-A stated residents have access to a menu online. When the surveyor requested a copy of the menu, CNS-A stated her computer was in off-site office and inaccessible to her at that moment. The licensee's Food Service policy dated August 1, 2021, indicated resident participation in menu planning is encouraged, and will be informed in advance of any menu changes. The policy lacked verbiage to include menu was prepared a week in advance and provided to the residents. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485			
0 490 SS=F	144G.41 Subd 1 (13) (ii)-(vii) Minimum requirements (iv) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance; (v) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the	0 490			

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0 490	Continued From page 11 community, and provide the name of or other identifying information about persons responsible for providing this assistance; (vi) provide culturally sensitive programs; and (vii) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to have a daily program of social and recreational activities based on individual and group interests, physical, mental, and psychosocial needs, that create opportunities for active participation in the community at large. This had the potential to affect all residents of the licensee. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On November 27, 2023, at 9:50 a.m., during the entrance conference, clinical nurse supervisor (CNS)-A stated licensee provided a daily program of social and recreational activity. On November 27, 2023, at 11:30 a.m., during the	0 490			

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0 490	Continued From page 12 facility tour, the surveyor did not observe a posted program of social and recreational activities. The surveyor also observed that all residents: R2, R3, and R4, remained in their rooms either sleeping or watching television, unengaged in any social or recreational activities for the duration of the survey. On November 30, 2023, at 11:44 a.m., CNS-A stated the licensee used to have someone to assist the residents in activities, but the residents refused to come out of their rooms. CNS-A also stated staff go into resident rooms during their shifts to engage residents in conversations but did not specify what the conversation entails. Licensed assisted living director (LALD)-B stated the resident population licensee has "want to run their own shows", making it difficult to engage them in activities. The licensee's Scope of Service policy dated August 1, 2021, indicated licensee will provide assistance with arranging transportation for personal, social and recreational activities, daily socialization and recreation, and culturally sensitive programs and activities. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 490			
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be	0 510			

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0 510	Continued From page 13 consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program to comply with acceptable health care, medical, and nursing standards for infection control. This deficient practice had the potential to affect all the licensee's 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: HANDWASHING On November 27, 2023, at 1:15 p.m., the surveyor observed licensed assisted living director (LALD)-B enter office wearing gloves. LALD-B removed medications from locked medication cabinet and performed medication set up for R4. LALD-B returned medications to medication cabinet and placed filled med boxes in an unlocked file drawer in the office. LALD-B	0 510			

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0 510	Continued From page 14 removed gloves. Hand hygiene not observed before LALD-B removed R2's medication boxes from unlocked file drawer and a bin containing R2's medication from medication cabinet. LALD-B left office to wash hands in bathroom. LALD returned to office and donned gloves prior to performing medication set up for R2. CARES On November 28, 2023, at 8:30 a.m., the surveyor observed unlicensed personnel (ULP)-C enter R3's room wearing gloves. Hand hygiene prior and glove donning not observed. ULP-C provided resident with oral care and bed bath then removed dressing from suprapubic catheter insertion site and discarded into trash receptacle. ULP-C washed catheter insertion site and perineal area. Without changing gloves or performing hand hygiene, ULP-C reapplied a dry gauze dressing to suprapubic catheter insertion site, finished bed bath, and applied lotion to R3. On November 30, 2023, at 11:44 a.m., clinical nurse supervisor (CNS)-A stated staff are required to change gloves and perform hand hygiene separately for many procedures and that all staff are retrained on infection control techniques. The licensee's Infection Control policy dated August 1, 2021, indicated hands should be washed at the following times: -after changing beds; -before assisting with medications; -before and after treatments; -after all pet care; -after housekeeping; -after emptying bedpans; -after assisting resident to the toilet; -after removing items from the floor;	0 510			

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0 510	Continued From page 15 -before preparing food; -before feeding residents; -after using bathroom; -after coughing or sneezing; -after smoking; -after handling plants; and -after removing gloves. The Centers for Disease Control's (CDC), "CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings" dated November 29, 2022, under section 5a.2 (§ a, b, c, d, e, f) read: 2.) Use an alcohol-based hand rub or wash with soap and water for the following clinical indications: a.) Immediately before touching a patient. b.) Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices. c.) Before moving from work on a soiled body site to a clean body site on the same patient. d.) After touching a patient or the patient's immediate environment. e.) After contact with blood, body fluids or contaminated surfaces; and f.) Immediately after glove removal. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510			
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	0 640			

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0 640	Continued From page 16 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 through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment as required. This had the potential to affect all the licensee's current 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: The licensee failed to: - post the 911 emergency number in common areas and near telephones provided by the assisted living facility. On October 2, 2023, at 11:15 a.m., during a tour of the facility's common areas, and near	0 640			

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0 640	Continued From page 17 telephones on the first floor, the surveyor noted no 911 information was posted. On November 30, 2023, at 11:44 a.m., clinical nurse supervisor (CNS)-A stated the licensee was not aware of the posting requirement. The licensee's Employee Safety policy dated August 1, 2021, indicated information about safety/security practices are incorporated into [licensee's] orientation program and includes, but is not limited to, the following: - Important Telephone Numbers (911). No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640			
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision.	0 660			

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0 660	Continued From page 18 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included baseline testing and screening for two of two employees (unlicensed personnel (ULP)-C, ULP-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: The Facility TB Risk Assessment form dated July 1, 2023, identified the facility was a low risk for transmission. ULP-C was hired on June 20, 2020, under the licensee's former comprehensive license and started providing assisted living services August 1, 2021. ULP-C's employee record included a Baseline TB Screening Tool dated March 23, 2022, an Interferon-Gamma Release Assay (IGRA) (a blood test for TB infection) laboratory result dated March 11, 2021, and chest x-ray dated March 10, 2021. ULP-C's record lacked a positive TB test prior to completing a chest x-ray. ULP-D was hired on October 23, 2023. ULP-D's employee record included a Baseline TB Screening tool dated November 28, 2023, and a	0 660			

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0 660	Continued From page 19 chest x-ray result dated October 18, 2023. ULP-D's employee record lacked documentation of a TB Skin Test or IGRA laboratory result. On November 30, 2023, at 11:45 a.m., clinical nurse supervisor (CNS)-A stated they did not understand the requirements of a TB control program and employees were required to show evidence of negative TB results prior to providing care for residents. The CDC guideline titled Tuberculosis Screening, Testing, and Treatment of U.S. Health Care Personnel: Recommendations from the National Tuberculosis Controllers Association and CDC, 2019, includes the following updated recommendations: -TB screening with an individual risk assessment and symptom evaluation at baseline -TB testing with an IGRA or a tuberculosis skin test (TST) for persons without documented prior TB disease or latent TB infection (LTBI) -no routine serial testing at any interval after baseline in the absence of a known exposure or ongoing transmission -encouragement of treatment for all health care personnel with untreated LTBI -annual symptom screening for health care personnel with untreated LTBI -annual TB education of all personnel. The licensee's undated Infection Control Program document indicated it is the policy of [licensee] to screen all employees for the presence of inactive or active tuberculosis at the time of employment and at least annually thereafter. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 660			

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0 660	Continued From page 20 (21) days	0 660			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation and record review, the licensee failed to have a written emergency preparedness plan (EPP) with all the required content and failed to post an emergency preparedness plan prominently. This had the potential to affect all staff, visitors, and residents	0 680			

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0 680	Continued From page 21 receiving services under the license. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a 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 a facility tour on November 27, 2023, at 10:15 a.m., the surveyor did not observe a posting of the licensee's emergency plan, emergency exit diagrams posted in conspicuous places on each floor, or emergency exit diagrams in residents' rooms. The [licensee] Emergency Preparedness Manual, updated July 1, 2023, lacked evidence of the following required content: - a quarterly review of missing resident plan; - a description of the population needs served by the licensee; - procedure for tracking staff and residents; - policies to address subsistence needs for staff and residents during an emergency; - a communication plan that included: - names and contact information for staff, resident physicians, other facilities; - a means to provide information regarding the facility's needs, and its ability to provide assistance to include information about their occupancy; and -a method of sharing information from the emergency plan with residents and their families.	0 680			

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0 680	Continued From page 22 Licensee's Emergency Preparedness policy dated August 1, 2021, indicated each resident's service needs are identified and prioritized upon admission and the EPP would be posted on each floor of the facility. Licensee's Missing Resident policy dated August 1, 2021, indicated the director and clinical nurse supervisor will review the missing resident procedure at least quarterly and document changes to the plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 720 SS=F	144G.43 Subd. 2 Access to records The facility must ensure that the appropriate records are readily available to employees and contractors authorized to access the records. Resident records must be maintained in a manner that allows for timely access, printing, or transmission of the records. The records must be made readily available to the commissioner upon request. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure that personnel and resident records were readily available for access to the commissioner upon request. 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	0 720			

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0 720	Continued From page 23 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 entrance conference on November 27, 2023, at 9:50 a.m., clinical nurse supervisor (CNS)-A stated resident and employee records would be available to the surveyor using the licensee's electronic and paper records. At the end of the entrance conference the surveyor drew the attention of the licensee to the entrance email sent that morning and pointed out all the required documents after the facility tour. On November 27, 2023, at 1:03 p.m., the surveyor sent the licensee a reminder email of the required documents: - discharge or deceased resident roster; - accidents/incidents reports past 6 months; - Minnesota Adult Abuse Reporting Center (MAARC) Reports past 6 months; - policies and procedures; - infection control/TB program policies and procedures; - employee record; and - copy of current assisted living bill of rights and resident complaint form. On November 27, 2023, at 2:40 p.m., the surveyors called a meeting with licensed assisted living director (LALD)-B to review the survey process, expectations, and plan for the next day. The surveyors requested that clinical nurse supervisor (CNS)-A be on-site with her computer to ensure the surveyors received requested documents timely.	0 720			

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0 720	Continued From page 24 On November 28, 2023, by 10:00 a.m., the licensee had sent: - employee record; - bill of rights; - blank contract; - blank admission packet. On November 28, 2023, at 10:05 a.m., the surveyors called CNS-A on the phone, CNS-A stated she was still working on sending more records to the surveyors. On November 28, 2023, at 12:03 p.m., the surveyors called LALD-B concerning the requested records. LALD-B stated she was not sure what records CNS-A had sent, and stated she will go through the office to bring the surveyors employee files and promised to be at the assisted living facility location within 30 minutes. On November 28, 2023, at 1:10 p.m., LALD-B arrived with two employee folders and opened a locked cabinet in the office where the surveyors were and pulled out two resident charts. LALD-B stated she was not very conversant with assisted living records requirements. On November 28, 2023, at 2:45 p.m., the surveyors had a meeting with LALD-B and pointed out the records requested but not yet received: - abuse prevention plan; - 90-day nursing assessments; - medication administration records; - individual medication management plans; - individual treatment or therapy management plans; and - provider orders for medications and treatments licensee managed.	0 720			

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0 720	Continued From page 25 On November 29, 2023, at 9:19 a.m., the surveyors called LALD-B to remind them the engineering surveyor had not received any of the requested documents to conduct the fire protection and physical environment portion of the survey. On November 29, 2023, at 10:02 a.m., the surveyors spoke over the phone with LALD-B to request them to be available for an exit conference. LALD-B stated CNS-A was taking care of two ventilator clients whom she could not leave without supervision. On November 29, 2023, at 7:21 p.m., through email, CNS-A sent the surveyors some of the documents that were requested the previous day: - abuse prevention plan; - 90-day nursing assessments; - medication administration records; - individual medication management plans; and - individual treatment or therapy management plans. On November 30, 2023, at 11:44 a.m., CNS-A stated she was very busy as she oversaw the licensee's comprehensive license and assisted living facilities. The licensee's Request for Records policy dated August 1, 2021, indicated [licensee] will comply with written requests for copies of records or a summary of the information in the records unless such information is detrimental to the resident's physical or mental health or would cause him or her to harm himself or herself or another. The policy lacked verbiage when dealing with the commissioner's agents.	0 720			

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0 720	Continued From page 26 No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 720			
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that are interconnected so actuation of one alarm causes	0 780			

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0 780	Continued From page 27 all alarms in the dwelling unit to actuate. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On November 27, 2023, at 12:15 p.m., survey staff toured the facility with licensed assisted living director (LALD)-B. It was observed the sleeping rooms were equipped with smoke alarms that were not interconnected with the other smoke alarms in the dwelling unit so actuation of one alarm would cause all alarms to operate. It was also observed the smoke alarm in bedroom #3 was beeping to indicate the battery was low and the smoke alarm in the kitchen had been disabled by pulling the battery out. LALD-B had the battery replaced in the kitchen smoke alarm at the time of the survey. On November 27, 2023, at 12:15 p.m., LALD-B verified the smoke alarms were not interconnected and the low battery of smoke alarm in bedroom #3. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780			

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0 790	Continued From page 28	0 790			
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain fire extinguishers maintenance with monthly inspections and not at full charge. This had the potential to affect all current 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 November 27, 2023, at 12:15 p.m., survey staff toured the facility with licensed assisted living director (LALD)-B. It was observed the	0 790			

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0 790	Continued From page 29 portable fire extinguishers were tagged showing the required annual service date but lacked the records to show the required monthly visual inspections to date. One of the fire extinguishers had an annual certification tag indicating it was new in April 2023, but it was undercharged and the yellow indicator arrow was not in the green zone of the meter. During interview on November 27, 2023, at 12:15 p.m., staff explained to LALD-B the portable fire extinguishers must be provided annual certification tags and also with monthly visual inspection or "quick checks" of each extinguisher by their employees to ensure all portable extinguishers are readily available, fully charged, and operable, at their designated location with no obvious physical damage or condition to the extinguisher to prevent their operation when needed. LALD-B acknowledged the the maintenance deficiencies and stated she will make sure the fire extinguishers are fully charged and her staff knows how to do the monthly checks. 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.	0 800			

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0 800	Continued From page 30 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain 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. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On November 27, 2023, at 12:15 p.m., survey staff toured the facility with licensed assisted living director (LALD)-B. It was observed the dining room flooring was cracked in multiple locations and parts of the tile were missing. The damage to the tile floor followed the path of travel from the double doors in the dining room, used as an entry for residents in wheelchairs, through the kitchen. The edges of the tiles where pieces were missing appeared to be sharp and loose. Damaged flooring materials that are broken and loose are a potential tripping hazard. It was observed the downstairs bathroom had water damage on the ceiling adjacent to the door and plastic ceiling cover. The ceiling was dry to	0 800			

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0 800	Continued From page 31 the touch, but the damaged materials and finishes had not been fixed or replaced. On November 27, 2023, at 12:15 p.m., when survey staff asked LALD-B what the damage was caused by, she stated she was not sure and would look into it. It was observed the downstairs bulkhead had water damage on the bottom of it and the paint was chipping and falling off of it. The bulkhead was dry to the touch, but the damaged materials and finishes had not been fixed or replaced. On November 27, 2023, at 12:15 p.m., LALD-B stated she did not know what caused the damage. TIME PERIOD FOR CORRECTION: Twenty-one (21) 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	0 810			

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0 810	Continued From page 32 receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On November 29, 2023, licensed assisted living	0 810			

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0 810	Continued From page 33 director (LALD)-B provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee FSEP, titled "Fire Safety", dated August 2023, failed to include the following: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronyms R.A.C.E. (Remove, Alarm, Confine and Extinguish or Evacuate) and P.A.S.S. (Pull, Aim, Squeeze, and Sweep) but failed to include procedures for how staff are to complete each step. The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures residents should follow in case of a fire or similar emergency. The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation nor did it include instructions for staff to follow in case of relocation. During an interview on November 29, 2023, at 11:00 a.m., LALD-B stated she understood the areas of her policy that were incomplete and	0 810			

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0 810	Continued From page 34 would work on bringing them into compliance. TRAINING Record review indicated the licensee failed to provide evacuation training to residents at least once per year. LALD-B was unable to provide documentation showing any training offered to residents on the fire safety and evacuation plan. Record review indicated the licensee failed to provide training to employees on the FSEP upon hire and at least twice per year as evidenced by the "knowledge assessment" provided by an online third-party platform. LALD-B was unable to provide documentation showing required training on facility-specific plans. One in-person staff training on the facility-specific plan was completed on 10/06/2023. No other documentation was provided. During an interview on November 29, 2023, at 11:00 a.m., LALD-B stated residents review fire safety and evacuation procedures when they are admitted to the facility, but she had not offered any additional training each year for residents. LALD-B also stated staff receive training on the FSEP twice per year, and would email it to the surveyor. Survey staff agreed to review any additional documentation on staff training, but none was provided after the interview was completed. DRILLS Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month as evidenced by the fire drill reports provided. Evacuation drills were conducted on 04/24/2023 and 10/29/2023 for the morning and evening shifts. No other	0 810			

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0 810	Continued From page 35 documentation was provided. During an interview on November 29, 2023, at 11:00 a.m., LALD-B stated there were no further documented drills for the facility and verified this deficient condition. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810			
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content. This had the potential to affect all residents living in the assisted living 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	0 910			

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0 910	Continued From page 36 or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: On November 27, 2023, at 9:50 a.m., during the entrance conference, the surveyor requested for the licensee's assisted living contract. On November 27, 2023, at 2:37 p.m., the surveyor received the licensee's blank Assisted Living Contract through email. The Assisted Living Contract lacked documentation of the Health Facility Identification (HFID) number of the facility in a conspicuous place and manner. On November 30, 2023, at 11:44 a.m., clinical nurse supervisor (CNS)-A and licensed assisted living director (LALD)-B stated licensee was not aware of the requirement and all resident contracts will be missing the HFID number. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 910			
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law.	0 970			

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0 970	Continued From page 37 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal property of a resident. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On November 27, 2023, at 9:50 a.m., during the entrance conference, the surveyor requested for the licensee's assisted living contract. On November 27, 2023, at 2:37 p.m., the surveyor received the licensee's blank Assisted Living Contract through email. The assisted living contract the Assisted Living Contract had two sections with a liability language: - Section indemnification read - [licensee] shall not be liable for any damage or injury to the resident, or any other person, or to any property, occurring on the premises, or any part thereof, or in common areas thereof, and the resident agrees to hold [licensee] harmless from any claims or damages unless caused solely by negligence of [licensee]. - Section liability read - the resident agrees to be liable and responsible for all obligations herein	0 970			

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0 970	Continued From page 38 referenced, monetary and otherwise, of the resident and where this contract has been executed by a party designated below. On November 30, 2023, at 11:44 a.m., clinical nurse supervisor (CNS)-A stated licensee was not aware of the waiver language in the contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970			
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective	01620			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34307	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/30/2023
NAME OF PROVIDER OR SUPPLIER OLYDIA HOME CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 7243 MORGAN AVENUE NORTH BROOKLYN CENTER, MN 55430		
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01620	Continued From page 39 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) completed 14-day and 90-day comprehensive nursing assessments within the required timeframe for two of two residents (R2 and R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2 R2 was admitted to licensee on June 30, 2022, for assisted living services. R2's diagnoses were antisocial personality, history of alcohol abuse, history of methamphetamine use, and mild neurocognitive disorder. R2's Service Plan dated June 30, 2022, indicated R2 received the following services: resident review and assessments, medication management, dressing, grooming, toileting, and assistance with mobility. R2's nursing assessment records included an initial assessment completed on June 30, 2022, and a 90-day nursing assessment completed on	01620			

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NAME OF PROVIDER OR SUPPLIER OLYDIA HOME CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 7243 MORGAN AVENUE NORTH BROOKLYN CENTER, MN 55430		
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01620	Continued From page 40 August 13, 2023. R2's assessments were 409 days apart. R2's record did not have any further assessments completed by the registered nurse (RN). R3 R3 was admitted to licensee on July 8, 2022, for assisted living services. R3's diagnoses were quadriplegia, and sacral ulcer. R3's Service Plan dated July 8, 2022, indicated R3 received the following services: resident review and assessments, medication management, dressing, grooming, toileting, behavior management, and assistance with transfer. R3's nursing assessment records included an initial assessment completed on July 8, 2022, and a 90-day nursing assessment completed on August 13, 2023. R3's assessments were 401 days apart. R3's record did not have any further assessments completed by the registered nurse (RN). On November 30, 2023, at 11:44 a.m., clinical nurse supervisor (CNS)-A stated licensee had completed all resident assessments but thought the surveyors only requested for what she had sent. CNS-A also stated she would send the surveyors the three latest nursing assessments for R2 and R3 before the day's end. However, the surveyor did not receive the assessments. The licensee's Assessment and Reassessment policy dated August 1, 2021, RN will provide a reassessment visit to update the evaluation of the resident and services no more than 14 days after	01620			

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01620	Continued From page 41 initiation of services. Also, the policy indicated ongoing resident reassessments must be conducted by an RN and cannot exceed 90 days from the last date of assessment. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620			
01650 SS=F	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 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	01650			

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01650	Continued From page 42 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 included all required content for two of two residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2 R2 was admitted to licensee on June 30, 2022, for assisted living services. R2's Service Plan dated June 30, 2022, indicated R2 received the following services: resident review and assessments, medication management, dressing, grooming, toileting, and assistance with mobility. R3 R3 was admitted to licensee on July 8, 2022, for assisted living services. R3's Service Plan dated July 8, 2022, indicated R3 received the following services: resident review and assessments, medication management, dressing, grooming, toileting, behavior management, and assistance with	01650			

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01650	Continued From page 43 transfer. R2 and R3's service plan lacked: - the fees for services; - the action to be taken if the scheduled service cannot be provided; - information and a method to contact the facility; - 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 - 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. On November 30, 2023, at 11:44 a.m., clinical nurse supervisor (CNS)-A stated licensee was not aware of the missing service plan content. The licensee's Service Plan policy dated August 1, 2021, indicated the service plan includes the following content: a. a description of the services to be provided; the service description may be in the form of the resident's care plan developed with the resident/responsible party; b. the fees for services and the frequency of each service, according to the resident's current review or assessment and resident preferences; c. the identification of the staff or categories of staff who will provide the services; d. the schedule and methods of monitoring reviews or assessments of the resident; e. the schedule and method of monitoring staff providing services; f. A contingency plan that includes the following:	01650			

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01650	Continued From page 44 i. Action to be taken if the scheduled service cannot be provided; ii. Information and method for a resident or resident's representative to contact the facility; iii. 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; iv. The identification of and information as to who has the authority to sign for the resident in an emergency; and v. Circumstances in which emergency medical services are not to be summoned and declarations made by the resident related to health care directives. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650			
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions;	01730			

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01730	Continued From page 45 (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an individual medication management plan (IMMP) to include all required content for two of two residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	01730			

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01730	Continued From page 46 or has the potential to affect a large portion or all of the residents). The findings include: R2 R2's Service Plan dated June 30, 2022, indicated R2 received the following services: resident review and assessments, medication management, dressing, grooming, toileting, and assistance with mobility. On November 28, 2023, at 7:50 a.m., the surveyor observed unlicensed personnel (ULP)-C administer medications to R2 in his room. R3 R3's Service Plan dated July 8, 2022, indicated R3 received the following services: resident review and assessments, medication management, dressing, grooming, toileting, behavior management, and assistance with transfer. On November 28, 2023, at 8:10 a.m., the surveyor observed ULP-C administer medications to R3 in his room. On November 29, 2023, at 10:19 a.m., the surveyor reviewed R2 and R3's medication administration record (MAR), service plan, and service checkoff forms, none of which contained the required information for IMMP. R2 and R3's record lacked an individual medication management plan with the following content: - a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's	01730			

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01730	Continued From page 47 directions; - identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; - identification of medication management tasks that may be delegated to unlicensed personnel; - procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and - any resident-specific requirements relating to documenting medication administration. On November 30, 2023, at 11:44 a.m., clinical nurse supervisor (CNS)-A stated R2 and R3's IMMP were in the licensee's main office and they would send them by end of the business day. However, the surveyor did not receive R2 and R3's IMMP. The licensee's Service Plan for Medication Management policy dated August 1, 2021, indicated licensee will prepare and document a medication management plan as part of the service plan for each resident receiving medication management services. The policy also indicated the written medication management plan includes the following provisions: a. a statement describing the medication management services to be provided; b. a description of the storage of medications based on the resident assessment and addressing: i. resident preference; ii. risk of diversion; iii. instructions per manufacturer; c. documentation procedures; d. procedures for medication reconciliation; e. identification of person(s) responsible for	01730			

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01730	Continued From page 48 monitoring medication supplies and ensuring refills are ordered/timely; f. description of medication management tasks to be delegated to unlicensed personnel; g. plans for staff notifying the licensed health professional when/if a problem with medication management services arises; and h. any resident-specific requirements related to documenting medication administration, verification that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730			
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 the required content for one of two residents (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	01770			

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01770	Continued From page 49 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 November 27, 2023, at 10:00 am., licensed assisted living director (LALD)-B stated the licensee provided medication management services which included medication set up, and using computer and paper record for unlicensed personnel to administer to residents. On November 27, 2023, at 1:10 p.m., the surveyor observed LALD-B retrieve a bin of medications for R4 from a locked cabinet and an empty pillbox from an unlocked file drawer to set up medications for later administration to R4. LALD-B compared medication bottles for four medications (spironolactone, metoprolol, Farxiga, and Senna) to a paper Medication Administration Record (MAR) dated May 2023, then distributed medications to the pillbox. Documentation of medication set up was not observed. On November 28, 2023, at 1:20 p.m. LALD-B stated that they documented medication set up by making a note on the back of the MAR used for setting up the medications. Documentation did not include name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication set up. On November 29, 2023, at 12:45 p.m., clinical nurse supervisor (CNS)-A stated that medication set up is double checked against physician orders	01770			

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01770	Continued From page 50 on the computer and documented on a paper MAR. R4's record lacked a medication set up record to include name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication set up. The licensee's Medication Documentation policy dated August 1, 2021, indicated [licensee] will document medication set up according to the following: - Date of medication setup - Name of medication - Quantity of dose - Times to be administered. - Route of administration - Name/title of person completing medication setup No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770			
01810 SS=D	144G.71 Subd. 12 Medications; over-the-counter drugs; dietary An assisted living facility providing medication management services for over-the-counter drugs or dietary supplements must retain those items in the original labeled container with directions for use prior to setting up for immediate or later administration. The facility must verify that the medications are up to date and stored as appropriate. This MN Requirement is not met as evidenced	01810			

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01810	Continued From page 51 by: Based on observation, interview, and record review, the licensee failed to ensure over-the-counter medications or dietary supplements were kept up to date and that expired medications were disposed properly. This had the potential to affect all the licensee's residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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 November 28, 2023, at 9:45 a.m., the surveyor conducted a review of the medications in the office drawer with unlicensed personnel (ULP)-D, and made the following observations: - two bottles of Vitamin C 500 mg expired in June 2022. On November 28, 2023, at 9:55 a.m., ULP-D stated the registered nurse (RN) was responsible for all medication set up, and that ULPs did not handle any medications in bottles except when receiving and handing over to RN. On November 30, 2023, at 11:44 a.m., clinical nurse supervisor (CNS)-A stated all the medications in the drawer were house supplies and were not available to ULPs for administration. CNS-A also stated she had missed the expired medication in the drawer during the monthly audit.	01810			

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01810	Continued From page 52 The licensee's Medication Administration policy dated August 1, 2021, indicated the licensed nurse is responsible for assessing medications to assure that all medications are current and ordered by the prescriber and to identify any expired or outdated medications, which will be disposed according to policy. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01810			
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 interview and record review, the licensee failed to ensure written or electronically recorded prescriptions were obtained for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include:	01820			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34307	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/30/2023
NAME OF PROVIDER OR SUPPLIER OLYDIA HOME CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 7243 MORGAN AVENUE NORTH BROOKLYN CENTER, MN 55430		
(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
01820	Continued From page 53 R2 was admitted to licensee on June 30, 2022, for assisted living services. R2's diagnoses were antisocial personality, history of alcohol abuse, history of methamphetamine use, and mild neurocognitive disorder. R2's Service Plan dated June 30, 2022, indicated R2 received the following services: resident review and assessments, medication management, dressing, grooming, toileting, and assistance with mobility. R2's Medication Administration Record (MAR), dated November 1, 2023, through November 28, 2023, listed the medications, times to administer, and staff initials to indicate the resident was administered the following medication: Cymbalta 60 milligram (mg) by mouth once daily, gabapentin 300 mg capsules take one capsule three times a day, itraconazole 10 mg/milliliter (ml) administer 20 ml via gastrostomy tube (g-tube) twice daily, levetiracetam 1000 mg tablet take one tablet by mouth twice daily, pantoprazole sodium 40 mg tablet twice daily, cholecalciferol 2000 unit tablet take one tablet by mouth once daily, tamsulosin 0.4 mg capsule at bed time, and acetaminophen 500 mg tablets take two tablets by mouth three times a day. The licensee lacked signed orders for all medications they managed for R2. On September 18, 2023, at 2:30 p.m., clinical nurse supervisor (CNS)-A stated the licensee was using a home health certification form as their prescriber's orders, however, it was not provided to the surveyors.	01820			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34307	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/30/2023
NAME OF PROVIDER OR SUPPLIER OLYDIA HOME CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 7243 MORGAN AVENUE NORTH BROOKLYN CENTER, MN 55430		
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01820	Continued From page 54 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820			
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On November 27, 2023, at 10:15 a.m., the surveyor observed the medication refrigerator in the upstairs hallway. The refrigerator contained insulin pens and the hasp lock (type of locking	01880			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34307	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/30/2023
NAME OF PROVIDER OR SUPPLIER OLYDIA HOME CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 7243 MORGAN AVENUE NORTH BROOKLYN CENTER, MN 55430		
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01880	Continued From page 55 device that consists of two parts, a hinged metal plate and a loop) was closed but was noted to be unlocked. Unlicensed personnel (ULP)-C stated that the refrigerator was supposed to be kept locked, retrieved a set of keys, and locked refrigerator. On November 27, 2023, at 10:50 a.m., the surveyor observed a file cabinet containing resident records and medications in unlocked basement office. The key lock mechanism on the file cabinet was observed to be unlocked. File cabinet drawers were labeled with resident names and contained partially filled medication boxes for each resident. On November 28, 2023, at 8:00 a.m., the surveyor observed ULP-D retrieve medications from the unlocked file drawer in the office for R4. ULP-D stated the drawer was usually locked but did not know why it was unlocked at that time. On November 28, 2023, at 12:00 p.m., surveyor observed an expired bottle of Vitamin C 500 milligram (mg) tablets in an unlocked desk drawer in office. Desk drawer was noted to not have a locking mechanism. On November 29, 2023, at 12:15 p.m., clinical nurse supervisor (CNS)-C stated "stock medications" and medication for disposal were stored in the desk drawer. CNS-C acknowledged medications needed to be locked when stored in office. The licensee's Medication Storage policy, dated August 1, 2023, indicated when [licensee] is providing storage of medications outside of the resident's private living space, all prescription drugs are securely locked in substantially	01880			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34307	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/30/2023
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01880	Continued From page 56 constructed compartments according to the manufacturer's directions. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880			
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the care and services were provided according to acceptable health care, medical or nursing standards for two of two residents (R2, R3) with hospital-style bedrails. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2	02310	On December 1, 2023, the immediacy of correction order 2310 was removed, however non-compliance remained, and the scope and level remained unchanged.		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34307	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/30/2023
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02310	Continued From page 57 R2's diagnoses were antisocial personality disorder, history of alcohol abuse, mild neurocognitive disorder, and seizure disorder. R2's Service Plan dated June 30, 2022, indicated R2 received the following services: assistance with medications, vital signs, weight, and blood glucose, behavior monitoring, treatments, dressing, assistance with mobility including upper side rails, and grooming. R2's Home Health Care Plan dated June 30, 2022, indicated R2 was using hospital bed, hoyer lift, and upper bed rail; no further information related to the bed rail was included. On November 27, 2023, at 9:10 a.m., in R2's room, the surveyor observed unlicensed personnel (ULP)-D change, clean, and replace R2's colostomy bag. R2's hospital bed had bilateral rectangular bed rails measuring approximately 32 inches long by 15 inches tall. The middle space of the bed rail had 2 vertical bars about four inches from the sides of the bed rail and connected to four horizontal bars which were also about four inches apart. R2's Side-Rail Assessment Form dated June 30, 2022, outlined several areas of potential safety risk for R2 as follows: - resident non-ambulatory; - history of falls; - level of consciousness fluctuate; - alteration in safety awareness; - poor bed mobility; - visual challenges (not clearly assessed); and - difficulty with balance and trunk control. R2's bed rail assessment did not address the following:	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34307	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/30/2023
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02310	Continued From page 58 - installation per manufacturer's instructions; - secure attachment of bed rail (left blank); - bed rail measurements (left blank); and - any necessary information related to interventions to mitigate safety risk or negotiated risk agreements. R3 R3's diagnoses were quadriplegia, colostomy status, other cystostomy status, chronic ulcer of heel and midfoot with necrosis muscle, and chronic ulcer unspecified of lower leg with necrosis of bone. R3's Service Plan dated July 8, 2022, indicated R3 received the following services: assistance with medications, vital signs, weight, and blood glucose, behavior monitoring, treatments, dressing, assistance with mobility including upper side rails, and grooming. R3's Home Health Care Plan dated July 8, 2022, indicated R3 had upper bed rail; no further information related to the bed rail was included. On November 27, 2023, at 11:30 a.m., the surveyor observed ULP-C assist to feed R3 a snack. R3's hospital bed had bilateral rectangular bed rails measuring approximately 32 inches long by 15 inches tall. The middle space of the bed rail had 2 vertical bars about four inches from the sides of the bed rail and connected to four horizontal bars which were also about four inches apart. R3's Side-Rail Assessment Form dated July 8, 2022, outlined several areas of potential safety risk for R3 as follows: - resident non-ambulatory; - history of falls;	02310			

Minnesota Department of Health

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02310	Continued From page 59 - level of consciousness fluctuate; - alteration in safety awareness; - poor bed mobility; and - difficulty with balance and trunk control. R3's bed rail assessment did not address the following: - installation per manufacturer's instructions; - secure attachment of bed rail (left blank); - bed rail measurements (left blank); and - any necessary information related to interventions to mitigate safety risk or negotiated risk agreements. On November 30, 2023, at 12:30 p.m., clinical nurse supervisor (CNS)-A stated licensee uses a template to ensure all resident bed rails meet the required standard. CNS-A stated when licensee measures the bed rail and it meets the Food and Drug Administration's (FDA) requirement; they do not document the measurement, but if the bed rail does not meet the requirement, they advise the resident against using it. CNS-A stated licensee was not aware they were required to measure and keep that in resident record. The Food and Drug Administration's (FDA), A Guide to Bed Safety, dated 2000, and revised April 2010, indicated 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 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."	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34307	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/30/2023
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02310	Continued From page 60 The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Installation and use according to manufacturer's guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". Additionally, the MDH website indicated for hospital-style bed rails, the licensee must include in their documentation, the bed rail measurements and that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendations.	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34307	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/30/2023
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02310	Continued From page 61 No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	02310			
03090 SS=C	144.6502, 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 and interview, the licensee failed to ensure the required notice was posted at the main entry way of the facility to display statutory language to disclose electronic monitoring activity, potentially affecting all current residents in the assisted living facility, staff, and any visitors of the licensee. This practice resulted in a level one violation (a violation that has not 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 potential to affect a large portion or all of the clients). The finding include: On November 27, 2023, at 10:00 a.m., upon arrival to the licensee's facility, the surveyor	03090			

Minnesota Department of Health

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03090	Continued From page 62 observed outside the front entrance and inside the building had no posting for electronic monitoring devices. On November 29, 2023, at 1:30 p.m., clinical nurse supervisor (CNS)-A stated they were unaware of required posting of statutory language for electronic monitoring. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090			

Type: Full
Date: 11/27/23
Time: 12:15:55
Report: 1029231348

Food and Beverage Establishment Inspection Report

Page 1

Location:

Olydia Home Care Inc
7243 Morgan Avenue North
Brooklyn Center, MN55430
Hennepin County, 27

Establishment Info:

ID #: 0039143
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 6127036144
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.

2-200 Employee Health

2-201.11C

**** Priority 1 ****

MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority at the specific request of the regulatory authority.

NO EMPLOYEE ILLNESS LOG. ILLNESS LOG EMAILED WITH REPORT.

Comply By: 11/28/23

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.

FISH PACKAGES THAWED ON TOP OF READY-TO-EAT PRODUCE. INSTRUCTED OPERATOR TO DISCONTINUE PRACTICE. OPERATOR DISCARDED PRODUCE.

Comply By: 11/27/23

2-500 Responding to contamination events

2-501.11

**** Priority 2 ****

MN Rule 4626.0123 Provide employees with procedures to follow for cleanup of vomit or fecal matter in the establishment. The procedures must minimize the spread of contamination to food and surfaces within the facility, and minimize the exposure of employees and consumers to contamination.

INCORRECT VOMIT/FECAL MATTER CLEANUP PROCEDURE EXPRESSED. PROVIDED VERBAL INSTRUCTIONS. VOMIT CLEANUP POSTER EMAILED WITH REPORT.

Comply By: 11/28/23

Type: Full
Date: 11/27/23
Time: 12:15:55
Report: 1029231348
Olydia Home Care Inc

Food and Beverage Establishment Inspection Report

Page 2

3-500C Microbial Control: date marking

3-501.17A **** Priority 2 ****

MN Rule 4626.0400A Mark the refrigerated, ready-to-eat, TCS food prepared and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded.

DATE MARKINGS ABSENT FROM HOT DOGS AND DELI MEAT. CORRECTED DURING INSPECTION.

Comply By: 11/27/23

4-300 Equipment Numbers and Capacities

4-302.13B **** Priority 2 ****

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

NO TEMP STICKERS OR MIN/MAX THERMOMETER FOR DISHWASHER. INSTRUCTED OPERATOR TO OBTAIN MEANS OF TESTING AND TEMP STICKERS WERE PROVIDED.

Comply By: 11/27/23

2-100 Supervision

2-102.12DMN

MN Rule 4626.0033D Post the certified food protection manager certificate.

CFPM CERTIFICATE NOT POSTED. INSTRUCTED OPERATOR TO POST.

Comply By: 12/01/23

2-300 Personal Cleanliness

2-301.12C

MN Rule 4626.0070C Food employees must avoid recontamination of their hands after handwashing by using a disposable paper towel or similar clean barrier to close faucet handles on a handwashing sink or the handle on a restroom door.

REPRESENTATIVE DID NOT TURN OFF FAUCET WITH PAPER. CORRECTED DURING INSPECTION.

Comply By: 11/27/23

3-500A Microbial Control: cooling

3-501.13E

MN Rule 4626.0380E Remove frozen fish from the reduced oxygen package prior to thawing under refrigeration or immediately after thawing if using the running water method of thawing.

PREVIOUSLY FROZEN VACUUM SEALED FISH THAWED SEALED. INSTRUCTED OPERATOR TO INTRODUCE OXYGEN BY OPENING PACKAGE PRIOR TO THAWING TO PRECLUDE PROLIFERATION OF CLOSTRIDIUM BOTULINUM.

Comply By: 11/27/23

Food and Equipment Temperatures

Type: Full
Date: 11/27/23
Time: 12:15:55
Report: 1029231348
Olydia Home Care Inc

Food and Beverage Establishment
Inspection Report

Process/Item: HOT DOGS
Temperature: 32 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: No

Process/Item: DELI MEAT
Temperature: 34 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: No

Process/Item: DELI MEAT
Temperature: 34 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: No

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

TOPIC DISCUSSED INCLUDED:

- HOLDING TEMPERATURES
- COOLING TIMES AND TEMPERATURES
- CHEMICAL AND HEAT SANITIZING
- EMPLOYEE HYGIENE AND SICKNESS EXCLUSION PROCEDURES
- BAREHAND CONTACT WITH READY TO EAT FOOD
- GENERAL CLEANING AND MAINTENANCE
- PEST CONTROL

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 1029231348 of 11/27/23.

Certified Food Protection ManagerLYDIA B. NKWONKAM

Certification Number: FM109132 Expires: 08/16/24

Inspection report reviewed with person in charge and emailed.

Signed:SEYBAH WEENQUOI
BCA FOOD SERVICES

Signed:Trevor McCliment
Trevor McCliment
Public Health Sanitarian
Metro District Office
651-201-3957
trevor.mccliment@state.mn.us

Report #: 1029231348

DEPARTMENT OF HEALTH

Minnesota Department of Health

Food, Pools, and Lodging Services

625 Robert Street North

St. Paul

No. of RF/PHI Categories Out

6

Date

11/27/23

No. of Repeat RF/PHI Categories Out

0

Time In

12:15:55

Legal Authority MN Rules Chapter 4626

Time Out

Olydia Home Care Inc

Address

7243 Morgan Avenue North

City/State

Brooklyn Center, MN

Zip Code

55430

Telephone

6127036144

License/Permit #

0039143

Permit Holder

Purpose of Inspection

Full

Est Type

Risk Category

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item

Mark "X" in appropriate box for COS and/or R

IN=in compliance

OUT= not in compliance

N/O= not observed

N/A= not applicable

COS= corrected on-site during inspection

R= repeat violation

Compliance Status

COS

R

Supervision

1

IN

OUT

PIC knowledgeable; duties & oversight

2

IN

OUT

N/A

Certified food protection manager, duties

Employee Health

3

IN

OUT

Mgmt/Staff;knowledge,responsibilities&reporting

4

IN

OUT

Proper use of reporting, restriction & exclusion

5

IN

OUT

Procedures for responding to vomiting & diarrheal events

Good Hygienic Practices

6

IN

OUT

N/O

Proper eating, tasting, drinking, or tobacco use

7

IN

OUT

N/O

No discharge from eyes, nose, & mouth

Preventing Contamination by Hands

8

IN

OUT

N/O

Hands clean & properly washed

9

IN

OUT

N/A

N/O

No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed

10

IN

OUT

Adequate handwashing sinks supplied/accessible

Approved Source

11

IN

OUT

Food obtained from approved source

12

IN

OUT

N/A

N/O

Food received at proper temperature

13

IN

OUT

Food in good condition, safe, & unadulterated

14

IN

OUT

N/A

N/O

Required records available; shellstock tags, parasite destruction

Protection from Contamination

15

IN

OUT

N/A

N/O

Food separated and protected

16

IN

OUT

N/A

Food contact surfaces: cleaned & sanitized

17

IN

OUT

Proper disposition of returned, previously served, reconditioned, & unsafe food

Compliance Status

COS

R

Time/Temperature Control for Safety

18

IN

OUT

N/A

N/O

Proper cooking time & temperature

19

IN

OUT

N/A

N/O

Proper reheating procedures for hot holding

20

IN

OUT

N/A

N/O

Proper cooling time & temperature

21

IN

OUT

N/A

N/O

Proper hot holding temperatures

22

IN

OUT

N/A

Proper cold holding temperatures

23

IN

OUT

N/A

N/O

Proper date marking & disposition

24

IN

OUT

N/A

N/O

Time as a public health control: procedures & records

Consumer Advisory

25

IN

OUT

N/A

Consumer advisory provided for raw/undercooked food

Highly Susceptible Populations

26

IN

OUT

N/A

Pasteurized foods used; prohibited foods not offered

Food and Color Additives and Toxic Substances

27

IN

OUT

N/A

Food additives: approved & properly used

28

IN

OUT

Toxic substances properly identified, stored, & used

Conformance with Approved Procedures

29

IN

OUT

N/A

Compliance with variance/specialized process/HACCP

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

GOOD RETAIL PRACTICES

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

Mark "X" in box if numbered item is not in compliance

Mark "X" in appropriate box for COS and/or R

COS= corrected on-site during inspection

R= repeat violation

Compliance Status

COS

R

Safe Food and Water

30

IN

OUT

N/A

Pasteurized eggs used where required

31

Water & ice obtained from an approved source

32

IN

OUT

N/A

Variance obtained for specialized processing methods

Food Temperature Control

33

Proper cooling methods used; adequate equipment for temperature control

34

IN

OUT

N/A

N/O

Plant food properly cooked for hot holding

35

IN

OUT

N/A

N/O

Approved thawing methods used

36

Thermometers provided & accurate

Food Identification

37

Food properly labeled; original container

Prevention of Food Contamination

38

Insects, rodents, & animals not present

39

Contamination prevented during food prep, storage & display

40

Personal cleanliness

41

Wiping cloths: properly used & stored

42

Washing fruits & vegetables

Compliance Status

COS

R

Proper Use of Utensils

43

In-use utensils: properly stored

44

Utensils, equipment & linens: properly stored, dried, & handled

45

Single-use/single service articles: properly stored & used

46

Gloves used properly

Utensil Equipment and Vending

47

Food & non-food contact surfaces cleanable, properly designed, constructed, & used

48

X

Warewashing facilities: installed, maintained, & used; test strips

49

Non-food contact surfaces clean

Physical Facilities

50

Hot & cold water available; adequate pressure

51

Plumbing installed; proper backflow devices

52

Sewage & waste water properly disposed

53

Toilet facilities: properly constructed, supplied, & cleaned

54

Garbage & refuse properly disposed; facilities maintained

55

Physical facilities installed, maintained, & clean

56

Adequate ventilation & lighting; designated areas used

57

Compliance with MCIAA

58

Compliance with licensing & plan review

Food Recalls:

Person in Charge (Signature)

Date: 11/28/23

Inspector (Signature)