Electronically Delivered

August 15, 2022

Administrator
Epiphany Care Homes, LLC
3704 Cardinal Road
Minnetonka, MN 55345

RE: Project Number(s) SL20517015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on July 21, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation

that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5)(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, no immediate fines are assessed.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction for approval.

The correction order documentation should include the following:

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

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

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

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

Free from Maltreatment reconsideration requests should be addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place

St. Paul, MN 55164-0970 St. Paul, MN 55164-0970

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

Sincerely,

Casey DeVries, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-5917 Fax: 651-215-9697

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20517	A. BUILDING: _____ B. WING _____	07/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EPIPHANY CARE HOMES LLC	3704 CARDINAL ROAD MINNETONKA, MN 55345

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(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: SL20517015-0 On July 18, 2022, through July 21, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were seven residents, all of whom received services under the provider's Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 460 SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request	0 460		

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0 460	Continued From page 1 assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide a means for two of two residents (R1, R2) to request assistance for health and safety needs as required. The licensee did not have a system in place for residents at the facility to request assistance for health and safety needs 24 hours a day, seven days a week. This had the potential to affect all seven residents at the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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	0 460		

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0 460	Continued From page 2 portion or all of the residents). The findings include: The licensee held an assisted living with dementia care license and was licensed for a bed capacity of seven residents. During the entrance conference on July 18, 2022, at approximately 9:57 a.m., registered nurse (RN)-A confirmed the facility did not have a call system in place for residents to request assistance when needed. RN-A stated the resident area was relatively small and staff were always present, checked on the residents all the time and at least every two hours if they were in their rooms. RN-A said they had cameras placed throughout the property and although the monitoring in the dining room was temporarily down due to the remodeling, staff could view it and easily see resident movement. R1 R1's diagnoses included epilepsy, insomnia, hemiplegia affected right dominant side, history of falling, anxiety disorder, hypertension, esophageal reflux, hyperlipidemia and depressive disorder. On July 19, 2022, at approximately 8:27 a.m., the surveyor observed unlicensed personnel (ULP)-C enter R1's room and assisted R1 to move from lying in bed to sitting up at the side of bed. ULP-C placed a gait belt around R1's waist, placed slippers on her feet, and transferred R1 into her wheelchair. R1 propelled herself to the bathroom where ULP-G assisted R1 with toileting, hygiene and dressing. On July 19, 2022, at approximately 1:33 p.m., the	0 460		

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0 460	Continued From page 3 surveyor asked R1 if there was a way to call for help. R1 stated she had a bed alarm and when she gets out of bed, "it makes noise," but otherwise there was no other system. R2 R2's diagnoses included Parkinson's disease, iron deficiency anemia, vascular dementia, extrapyramidal and movement disorder, hyperlipidemia and depression. On July 19, 2022, at approximately 10:24 a.m., the surveyor observed ULP-G use a gait belt to assist R2 to ambulate from his room to the bathroom, where ULP-G completed morning cares. R2 cooperated with ULP-G, complying with requests to lift legs and arms when dressing and open mouth to brush teeth, but otherwise made no verbalizations or initiated conversation with ULP-G during the provision of care. On July 19, 2022, at approximately 6:29 a.m., the surveyor asked ULP-J how residents called for assistance during the overnight shift. ULP-J said it was mostly quiet during the night, that she checked on the residents every couple of hours or so and only one resident, R1, would call their name. ULP-J stated a couple of residents had bed alarms and one had a baby monitor turned on a night "for fall prevention." ULP-J said there was no "call light" system. On July 19, 2022, at approximately 8:21 a.m., the surveyor asked ULP-G how residents called for help and ULP-G said, "we watch the residents all the time." ULP-G stated, "I guess they would just have to yell out for help." On July 20, 2022, at approximately 9:15 a.m., RN-A said she had already ordered a new call	0 460		

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0 460	Continued From page 4 system and there would be a device for each resident's room, the bathroom and for each of the living rooms. The licensee's Uniform Disclosure of Assisted Living Services & Amenities, dated May 2, 2022, indicated it provided various, timed safety checks, and that it had an emergency call system, but did not provide a non-emergency all system. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 460		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the	0 470		

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0 470	Continued From page 5 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 interview and record review, the licensee failed to develop and document a facility staffing plan to meet the needs of all residents. This had the potential to affect all seven residents, staff and visitors of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: The licensee held an assisted living facility with dementia care license. The facility had a licensed bed capacity of seven residents with a census of seven residents. During the entrance conference on July 18, 2022, at approximately 10:29 a.m., registered nurse (RN)-A said their staff schedule was posted but they were not sure about a written staffing plan. RN-A said staffing would be based on meeting the needs of the residents. After the entrance conference at about 11:50	0 470		

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0 470	Continued From page 6 a.m., the surveyor observed the July 2022 staff schedule posted in the hallway in the pantry, which lead to the resident area. The document did not include information about a staffing plan. On July 20, 2022, at approximately 9:17 a.m., RN-A acknowledged a lack of a written staffing plan and stated they will work to correct that. The licensee's 4.06 Staffing and Scheduling policy, dated August 1, 2022, indicated the licensee will assure qualified employees will be scheduled to meet operation requirements and the needs of the residents. The policy also indicated the clinical nurse supervisor will develop and implement a written staffing plan that provides an adequate number of qualified staff to meet the resident's needs and would address: each resident's needs and acuity level, the ability of staff to timely meets resident needs, whether there was a secured dementia unit and staff experience. The policy did not address the requirement to evaluate the appropriateness of staffing levels in the facility at least twice each year. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) 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: (i) at least three nutritious meals daily with snacks	0 480		

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0 480	Continued From page 7 available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This had the potential to affect all seven residents living at the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated July 18, 2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		

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0 550	Continued From page 8	0 550		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to post required information related to the licensee's grievance procedure with all required content. This had the potential to affect all seven residents, staff and visitors of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 lacked a posting of the grievance procedure to include the name, telephone	0 550		

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0 550	Continued From page 9 number, and e-mail contact information for the individuals who were responsible for handling resident grievances. On July 18, 2022, at approximately 11:28 a.m., the surveyor toured the facility with office manager (OM)-B. Various required postings were located during the tour except for information regarding the facility's complaint process/grievance procedures. On a subsequent inspection with OM-B on July 19, 2022, at approximately 3:07 p.m., OM-B verified required information about the grievance process was not posted. The licensee's 2.10 Complaint/Grievance Posting policy, dated August 1, 2021, indicated the licensee will post, in a conspicuous place, information about our complaint/grievance procedure. The policy indicated it would post the name, telephone number and email contact formation for the individual(s) who are responsible for handling resident complaint/grievances. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 550		
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the	0 630		

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0 630	Continued From page 10 person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan was developed to include required content for two of two residents (R1, R2) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted to the facility on February 2, 2021. R1's diagnoses included epilepsy, insomnia, hypothyroidism, depression, hemiplegia affecting right side, hypertension and esophageal reflux disease. R1's service plan, dated June 6, 2022, indicated R1 received services including meals, assistance with activities of daily living, housekeeping and laundry and medication/treatment management.	0 630		

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0 630	Continued From page 11 R1's Vulnerability Assessment, dated February 2, 2022, indicated R1 was oriented to person, place and time; understood and followed directions; had chronic conditions; was not able to manage finances; and was able to report abuse/neglect concerns. R1's assessment lacked an individualized review of the resident's susceptibility to abuse to another individual, including other vulnerable adults; the residents' risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to the resident and other vulnerable adults. R2 R2 admitted to the facility on April 15, 2022. R2's diagnoses included osteoarthritis, systemic lupus erythematosus (inflammatory disease caused when the immune system attacks its own tissues, often affecting joints, skin, kidneys, heart and lung) and acute kidney failure. R2's service plan, dated July 19, 2022, indicated R2 received services including assistance with activities of daily living, meals, medication management, housekeeping and laundry. R2's Vulnerability Assessment, dated April 15, 2022, indicated R2 was not oriented to person, place and time; understood and followed directions; had chronic conditions; was not able to manage finances; had a history of wandering out of the building; and was not able to report abuse/neglect concerns. R2's assessment lacked an individualized review of the resident's susceptibility to abuse to another individual, including other vulnerable adults; the residents' risk of abusing other vulnerable adults; and statements of the specific measures to be taken	0 630		

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0 630	Continued From page 12 to minimize the risk of abuse to the resident and other vulnerable adults. On July 19, 2022, at approximately 12:25 p.m., registered nurse (RN)-A stated the vulnerability assessments did not include the content described in the statutes. RN-A said the same assessment was used for all residents and stated she would have to change it to include the missing content. The licensee's 6.05 Individual Abuse Prevention Plan policy, dated August 1, 2021, indicated the licensee will develop and implement an individual abuse prevention plan for each vulnerable adult. The policy indicated the individualized assessment would include the content described above. The licensee's 2.44 Vulnerable Adult Maltreatment - Prevention & Reporting policy, dated August 1, 2021, indicated the licensee develops individualized adult abuse prevention plans to identify vulnerability risks and develop measure to minimize maltreatment based on identified information. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
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	0 680		

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0 680	Continued From page 13 contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to have a written emergency preparedness plan with all the required content. In addition, the license failed to ensure its missing person policy and procedure was reviewed at least quarterly. This had the potential to affect all seven residents, staff and any visitors to the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	0 680		

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0 680	Continued From page 14 or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on July 18, 2022, at approximately 10:43 a.m., the surveyor requested the licensee's emergency preparedness (EP) plan. Registered nurse (RN)-A and office manager (OM)-B provided the plan, contained in three-ringed binders. One binder contained the main EP policy statement and polices including bomb threat, fire (evacuation plan & drills), heat & humidity, severe weather, water shortage, winter storms and missing resident (dated August 1, 2021). A second binder contained documents describing how to create an EP plan along with checklists, forms to complete for a custom plan (to shelter in place, for example), and sample MOUs (memorandum of understanding). Only parts of some forms were completed; most were not filled out. A third binder, the cover of which was titled "CMS Emergency Preparedness Rule Workbook: Long-Term Care: Nursing/Skilled Nursing Facilities, Wisconsin Department of Health Services." This binder was a compendium of forms (one completed listing facility, local, state and federal emergency contact information) templates, directions and guidance as tools from which to create a emergency preparedness plan. The licensee's plan lacked the following required content: -description of the population served by licensee; -process for emergency preparedness (EP) cooperation with state and local EP officials/organizations; -development of all policies/procedures, based on	0 680		

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0 680	Continued From page 15 assessment; and additional policies for: -process for EP collaboration with local, tribal, State and Federal EP; -policies & procedures for handling medical documents; -subsistence needs for staff and patents and sheltering in place; -medical documents; -use of volunteers; and -roles under a waiver declared by the Secretary; -development of a communication plan, including: -primary and alternate means for communication; -names and contact information; -emergency officials contact information; -methods for sharing information; -sharing information on occupancy needs; and -long term care family notifications; -EP training and testing program; -EP training program for staff (including documentation of training provided); and -annual EP testing requirements. On July 19, 2022, at approximately 11:53 a.m., RN-A and OM-B discussed their EP plan with the surveyor. OM-B said she participated in online training and was supposed to, at the end, have an emergency plan that met requirements. OM-B added that Appendix Z (the state-adopted emergency plan guidance) was a little overwhelming, confusing and the guidance to make the plan was "kind of Hodge podge." After reviewing the documents of their EP plan, OM-B said they would look to re-do the plan, keep it easier to read, more organized and simpler. RN-A said they would make changes to the plan to meet the requirements. RN-A also verified the missing person plan was dated August 1, 2021,	0 680		

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0 680	Continued From page 16 and had not been reviewed more recently. The licensee's 9.01 Emergency Preparedness Plan - Appendix Z Compliance policy, dated August 1, 2021, indicated it is the intent of the licensee that it has in place an effective and compliant Emergency Preparedness Plan. The policy indicates the licensee's EP plan will include all required elements of appendix Z. The licensee's 2.28 Missing Resident Policy, dated August 1, 2021, indicated it will review this policy and any individual resident plans that pertain to elopement at least quarterly, and all changes will be documented. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
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:	0 790		

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0 790	Continued From page 17 Based on observation and interview, the licensee failed to maintain facility fire extinguishers. 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the facility tour on July 18, 2022 between 11:00 a.m. and 12:35 p.m., survey staff toured the facility with the ULP-C. It was observed the fire extinguishers were not the required size of 2-A:10BC. ULP-C verbally confirmed survey staff observations during the facility tour. TIME PERIOD FOR CORRECTION: Twenty-on (21) days	0 790		
0 920 SS=C	144G.50 Subd. 2 (c) Contract information (c) The contract must include: (1) a disclosure of the category of assisted living facility license held by the facility and, if the facility is not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license; (2) a description of all the terms and conditions of the contract, including a description of and any limitations to the housing or assisted living	0 920		

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0 920	Continued From page 18 services to be provided for the contracted amount; (3) a delineation of the cost and nature of any other services to be provided for an additional fee; (4) a delineation and description of any additional fees the resident may be required to pay if the resident's condition changes during the term of the contract; (5) a delineation of the grounds under which the resident may be discharged, evicted, or transferred or have services terminated; (6) billing and payment procedures and requirements; and (7) disclosure of the facility's ability to provide specialized diets. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written assisted living contract that did not conflict with current statutes and rules for Assisted Living licensure for two of two residents (R1, R2) with records reviewed. This had potential to affect all seven residents of the facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 and R2's service agreements contained the following:	0 920		

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0 920	Continued From page 19 -a clause listed under the section "Limitation to our Home Care Services" section b." transfers requiring more than one (1) person from 10:30 p.m. to 6:30 a.m., unless resident purchases private duty aide during those hours. -a statement on page 29 of the contract in the section "Policies on Absence from Epiphany Care Home" which indicated: We will not complete re-admission after 5:00 p.m. and/or on weekends/holidays. R1 R1's service plan, dated June 6, 2022, indicated R1 received services including meals, assistance with activities of daily living, housekeeping and laundry and medication/treatment management. R1's Assisted Living Contract was dated and signed by R1 on February 2, 2021. R2 R2's service plan, dated July 19, 2022, indicated R2 received services including assistance with activities of daily living, meals, medication management, housekeeping and laundry. R2's Assisted Living Contract was dated and signed by R2 on April 14, 2022. Minnesota statutes 144G.41 Subd. 1, 11(ii) indicated the facility 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. Additionally, Minnesota Rule 4659.0180 Subp. 5 Direct-care staff availability, indicated: A minimum of two direct-care staff must be scheduled and available to assist at all times whenever a resident requires the assistance of two	0 920		

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0 920	Continued From page 20 direct-care staff for scheduled and reasonable foreseeable and unscheduled needs, as reflected in the resident's assessments and service plan. Also, Minnesota rule 4659.0140 subp. 7 Weekend assessments, indicated: An assisted living facility must be able to conduct a nursing assessment on a holiday or on a weekend for a resident who is ready to be discharged from the hospital and return to the facility. On July 20, 2022, at approximately 11:38 a.m., registered nurse (RN)-A was asked about the parts of the contract that conflicted with the Minnesota statutes and rules. RN-A said if a resident required assisted of two staff, they would deploy two staff at all times, including on the night shift, adding that right now, there were no residents who needed the assist of two staff. RN-A said they would have to make a decision if they only wanted to accept residents requiring the assist of one and would change the contract. With regard to evening, weekend and holiday assessments, RN-A said they had not had to and would prefer not to do weekend assessments but stated they would strike that language from the contract. RN-A acknowledged these contract clauses conflicted with assisted living rules. The licensee's 2.02 Acceptance of Resident's Policy, dated August 1, 2021, indicated it would only accept a resident if the facility had staff, sufficient in qualification, competency, and numbers, to adequately provide the services agreed to in each resident's assisted living contract and are within the scope of the licensee's disclosed services. The licensee's Uniform Disclosure of Assisted Living Services and Amenities (UDALSA), dated	0 920		

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0 920	Continued From page 21 May 2, 2022, indicated unlicensed staff were in the building and available to respond to resident requests 24/7, and licensed were either in the building, an attached building, or within the campus and available to respond to resident requests 24/7. The UDALSA indicated two direct-care staff were scheduled per day and evening shifts and one direct-care staff per night shift. The UDALSA also indicated transfers with assist of two staff were available from the licensee. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 920		
0 930 SS=C	144G.50 Subd. 2 (d-e; 1-4) Contract information (d) The contract must include a description of the facility's complaint resolution process available to residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints. (e) The contract must include a clear and conspicuous notice of: (1) the right under section 144G.54 to appeal the termination of an assisted living contract; (2) the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer; (3) contact information for the Office of Ombudsman for Long-Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints;	0 930		

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0 930	Continued From page 22 (4) the resident's right to obtain services from an unaffiliated service provider; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written assisted living contract with the required content for two of two residents (R1, R2) with records reviewed. This had potential to affect all seven current residents in the facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R and R2's assisted living contracts lacked the following required content: -the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer. R1 R1's service plan, dated June 6, 2022, indicated R1 received services including meals, assistance with activities of daily living, housekeeping and laundry and medication/treatment management. R1's assisted living contract was signed by the resident on February 2, 2021. R2	0 930		

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0 930	Continued From page 23 R2's service plan, dated July 19, 2022, indicated R2 received services including assistance with activities of daily living, meals, medication management, housekeeping and laundry. R2's assisted living contract was signed by the resident on April 14, 2022. On July 20, 2022, at approximately 11:41 a.m., registered nurse (RN)-A verified the residents' current contracts did not contain information about internal transfers and said they would add language regarding room changes. RN-A confirmed the same contract was used for all residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 930		
0 940 SS=C	144G.50 Subd. 2 (e; 5-7) Contract information (5) a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: (i) whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; (ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); (iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided;	0 940		

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0 940	Continued From page 24 (iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; (v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; (vi) a statement that residents may be eligible for assistance with rent through the housing support program; and (vii) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; (6) the contact information to obtain long-term care consulting services under section 256B.0911; and (7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written assisted living contract with the required content for two of two residents (R1, R2) with records reviewed. This had potential to affect all seven residents of the facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	0 940		

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0 940	Continued From page 25 R1 and R2's assisted living contracts lacked the following content: -a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: -whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); -whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; -whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; -a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; -a statement that residents may be eligible for assistance with rent through the housing support program; -a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; and -the contact information to obtain long-term care consulting services under section 256B.0911. R1 R1's service plan, dated June 6, 2022, indicated R1 received services including meals, assistance with activities of daily living, housekeeping and laundry and medication/treatment management. R1's assisted living contract was signed by the	0 940		

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0 940	Continued From page 26 resident on February 2, 2021. R2 R2's service plan, dated July 19, 2022, indicated R2 received services including assistance with activities of daily living, meals, medication management, housekeeping and laundry. R2's assisted living contract was signed by the resident on April 14, 2022. On July 20, 2022, at approximately 11:44 a.m., registered nurse (RN)-A stated they will have to make changes to the verbiage of the contracts. RN-A confirmed the same contract was provided all residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 940		
0 950 SS=F	144.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and	0 950		

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0 950	Continued From page 27 advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to offer the opportunity to identify a designated representative for three of three residents (R1, R2) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1's service plan, dated June 6, 2022, indicated R1 received services including meals, assistance with activities of daily living, housekeeping and laundry and medication/treatment management.	0 950		

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0 950	Continued From page 28 R1's assisted living contract was signed by the resident on February 2, 2021. R1's record did not contain a notice with the required statutory language for the resident to identify a designated representative or have documentation R1 declined to name a designated representative. R2 R2's service plan, dated July 19, 2022, indicated R2 received services including assistance with activities of daily living, meals, medication management, housekeeping and laundry. R2's assisted living contract was signed by the resident on April 14, 2022. R2's record did not contain a notice with the required statutory language for the resident to identify a designated representative or have documentation R2 declined to name a designated representative. On July 20, 2022, at approximately 11:51 a.m., registered nurse (RN)-A acknowledged neither R1 nor R2's contract provided opportunity for the resident to name a designated representative and the current contract did not have the space for the resident to initial and decline to name a representative. RN-A said, "it's going to be changed in the contract." RN-A confirmed the same contract was provided all residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950		
0 970 SS=F	144.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal	0 970		

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0 970	Continued From page 29 property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility'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 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: Following the entrance conference on July 18, 2022, at approximately 12:27 p.m., the licensee provided a current copy of the facility's Resident Handbook & Admission Packet, including the assisted living contract, as presented to residents and prospective residents. The assisted living contract include clauses that indicated the resident would waive the facility's liability for health, safety, or personal property of a resident. On pages 64 and 65, section 10. "No Liability of Community" of the contract indicated:	0 970		

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0 970	Continued From page 30 We have no responsibility to you or any third party for any personal property placed in the apartment or on any other location within community by you or owner of such personal property. We are not responsible to you or any third party for harm to or loss of any personal property by theft or any other cause. You assume all risk for harm to loss of any of your personal property and agree to release, indemnify, defend, and hold us harmless from any and all liability with respect to harm to or loss of any of your personal property. You are encouraged to secure an apartment or renter's insurance policy to protect against such loss, if so desired. Failure to secure such insurance may subject you to personal financial responsibility for such loss. On page 65, section 10 b. "No Liability of Community for Losses or Damages: indicated: You acknowledge familiarity with the apartment, the premises and services of community and are therefore willing to, and do, assume all risks associated with occupancy. You further acknowledge that we are not an insurer of your safety. Community, its employees, and its agents are not liable to you or to any other person for any loss or inconvenience of any kind, including personal injuries sustained by you or any other person, or any loss or damage to property, which is not the direct result of intentional or negligent acts in violation of applicable standards of care. We are not responsible for the actions of, or for any damages, injury or harm caused by third parties (such as other residents, family members, guests, intruders, or trespassers) who are not under our control. You agree to indemnify, defend, and hold community harmless from all liability connected with your occupancy of the apartment, except as limited herein. You further agree to indemnify, defend, and hold us harmless	0 970		

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0 970	Continued From page 31 from all liability caused by or related to your acts or the acts of your agents, family members or guests. On July 20, 2022, at approximately 12:07 p.m., registered nurse (RN)-A said "it screams legal to me" and would have to contact their attorney about it. RN-A confirmed the same contract was provided to all residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
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	01650		

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01650	Continued From page 32 authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the service plan included the required content for two of two residents (R1, R2) with records reviewed. This had the potential to affect all seven residents who received assisted living services from 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1's diagnoses included epilepsy, insomnia, hypothyroidism, depression, hemiplegia affecting right side, hypertension and esophageal reflux disease. On July 19, 2022, at approximately 8:27 a.m., the surveyor observed unlicensed personnel (ULP)-D assist R1 to get dressed. A few minutes later, another staff, ULP-G, applied an orthotic leg brace to R1's lower right leg. At approximately 8:54 a.m., the surveyor observed ULP-G	01650		

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01650	Continued From page 33 administer R1's morning medications. R1's service plan dated February 2, 2022, lacked the following content: -the fees for services and the frequency of each service according to the resident's current assessment and resident preferences; -the schedule and methods of monitoring assessments of the resident; -the schedule and methods of monitoring staff providing services; -a contingency plan that includes: -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 the 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. R2's diagnoses included osteoarthritis, systemic lupus erythematosus (inflammatory disease caused when the immune system attacks its own tissues, often affecting joints, skin, kidneys, heart and lung) and acute kidney failure. On July 18, 2022, at approximately 12:20 p.m., the surveyor observed ULP-C administer a midday medication to R2. R2's service plan, dated July 19, 2022, lacked the	01650		

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01650	Continued From page 34 following content: -the fees for services and the frequency of each service according to the resident's current assessment and resident preferences; -the schedule and methods of monitoring assessments of the resident; -the schedule and methods of monitoring staff providing services; -a contingency plan that includes: -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 the 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 July 20, 2022, at approximately 12:47 p.m., registered nurse (RN)-A acknowledged the resident service plans did not have all the required content. RN-A said the service plans were created via template from their electronic health record system, and this issue would apply to every resident's service plan. The licensee's Service Plan policy, Dated August 1, 2021, indicated the service plans will include: -Fees for services and the frequency of each to be provided based on the most recent assessment and resident preferences; -Schedule and method for the next planned	01650		

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01650	Continued From page 35 assessment or monitoring; -Schedule and method for the next planned monitoring of staff providing services; and -A contingency plan that includes: 1. Actions the licensee will take if scheduled service cannot be provided; 2. Information regarding how the resident can contact the licensee; 3. Names and contact information of persons the resident wishes to have notified in an emergency; 4. Names and contact information the resident wishes, if any, to have notified in an emergency or if there is a significant adverse change in the resident's condition; 5. Identification and contact information of who the resident has authorized, if any, to sign for the resident in an emergency; and 6. How the facility will support documented resident health care directive decisions, if any, including circumstances when emergency medical services are not to be summoned. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special	01790		

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01790	Continued From page 36 instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the	01790		

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01790	Continued From page 37 designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) developed written procedures for the unlicensed personnel (ULP) providing medications for residents having unplanned time away when the licensed nurse was not available. This had the potential to affect all seven residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on July 18, 2022, at approximately 10:10 a.m., RN-A stated the licensee provided medication management services for all residents at the facility and confirmed they stored and controlled residents' access to medications.	01790		

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01790	Continued From page 38 The licensee's 7.10 Medication Management - Planned & Unplanned Time Away policy, dated August 1, 2021, indicated for unplanned resident time away when a pharmacist or licensed nurse was not available, the RN could delegate this task to ULP if the RN had developed written procedures for the ULP including any special instructions or procedures regarding controlled substances that were prescribed for the resident. The written procedure must address: - the type of container or containers to be used for the medications appropriate to the provider's medication system; - how the container or containers must be labeled; - written information about the medications to be provided; - how the ULP must document in the resident's record that medications have been provided, including documenting the date the medications where provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; - how the RN would be notified that medications have been provided and whether the RN needs to be contacted before the medications are given to the resident or the designated representative; - a review by the RN of the completion of this task to verify that this task was completed accurately by the ULP; and - how the ULP must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each medication returned. On July 20, 2022, at approximately 12:25 p.m.,	01790		

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01790	Continued From page 39 RN-A confirmed they did not have a written procedure that documented how to prepare and send medications as required. RN-A said she could write a procedure to go along with the system they have in place with the pharmacy setting up medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the	01910		

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	20517	A. BUILDING: _____ B. WING _____	07/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EPIPHANY CARE HOMES LLC	3704 CARDINAL ROAD MINNETONKA, MN 55345

(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
01910	Continued From page 40 licensee failed to ensure documentation of the disposition of medications included all required information for one of one discharged resident (R8) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R8's medication administration record (MAR) for January and February 2022 indicated the resident received administration services daily. The record indicated R8 received medications for cholesterol, memory, an antidepressant, allergies, constipation, diabetes; atrial fibrillation, mood stabilization and pain. R8's nursing progress note dated February 10, 2022, indicated "Resident was discharged to VA group home in forest Lake at 10:00 per guardian request. All medications and belongs [sic] except what is noted in misc.where [sic] sent with. Report given to facility owner at time of discharge." Neither R8's progress note nor record contained further information regarding the disposition of the resident's medications. R8's discharge record lacked the medications' names, strengths, prescription numbers as appropriate, quantities and to whom the medications were given, date of disposition, names of staff and other individuals involved in the disposition.	01910		

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01910	Continued From page 41 On July 16, 2022, at approximately 12:15 p.m., registered nurse (RN)-D acknowledged R5's discharge paperwork had no record of the specific pills and quantity that were sent when the resident was discharged. RN-D said she did not know all this information was needed on the discharge record. The licensee's 7.23 Medication Disposal policy, dated August 1, 2021, indicated current unused medications managed by the licensee will be returned to the pharmacy for credit or given to the resident or representative when the resident's medications are no longer managed by the facility. The policy directed, upon disposition, the facility must document in the resident's record the items detailed above. No further information was provided. Time period for correction: Seven (7) days	01910		
02110 SS=F	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that	02110		

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	20517	A. BUILDING: _____ B. WING _____	07/21/2022

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EPIPHANY CARE HOMES LLC	3704 CARDINAL ROAD MINNETONKA, MN 55345

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02110	Continued From page 42 provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure required dementia care policies and procedures were developed and provided to each resident and/or the resident's legal and designated representative at the time of move-in. This had the potential to affect all seven residents in the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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	02110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02110	Continued From page 43 portion or all of the residents). The findings include: DEVELOPMENT OF REQUIRED POLICIES FOR DEMENTIA CARE During the entrance conference on July 18, 2022, at approximately 9:45 a.m., registered nurse (RN)-A stated they provided services for residents with dementia and memory loss and were licensed as an assisted living facility with dementia care. The licensee lacked or failed to develop the following policies related to dementia care: -philosophy of how services are provided based upon the assisted living facility license's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; -wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; -description of life enrichment programs and how activities are implemented; and -transportation coordination and assistance to and from outside medical appointments. On July 20, 2022, at approximately 12:51 p.m., RN-A acknowledged they had some but had not developed all required policies for dementia care. The licensee's 3.03 ALDC (assisted living dementia care) Dementia Care Philosophy policy, dated August 1, 2021, indicated the licensee supports person-centered dementia services in the following manner: the policy was undeveloped and included no further information. The licensee's 3.13 ALDC Wandering and	02110		

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02110	Continued From page 44 Elopement policy, dated August 1, 2022, indicated the licensee has systems in place to manage wandering, minimize opportunities for elopement and procedures in place to implement when a resident is missing or elopes. The policy was not further developed and lacked additional information of how it minimizes elopement risks. The licensee's 3.05 ALDC Life Enrichment Programs, Activities & Outdoor Space policy, dated August 1, 2021, indicated the licensee strives to provide valuable activities and life enrichment programs for residents. The policy was not fully developed and lacked description of its life enrichment programs and how activities are implemented. The licensee's 3.11 ALDC Transportation Coordination policy, dated August 1, 2021, indicated the licensee will help assist with and coordinate transportation to and from outside appointments for residents with Alzheimer's disease or other dementias. The policy was not further developed and lacked additional information of how it coordinates this service. DEMENTIA-CARE POLICIES NOT PROVIDED TO RESIDENTS R1 was admitted on February 2, 2021. R2 was admitted on April 15, 2022. R1and R2 both received services under the licensee's assisted living with dementia care license. R1 and R2's records lacked evidence or documentation the residents/representative received the policies and procedures related to	02110		

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02110	Continued From page 45 dementia care to be provided at the time of resident move-in to the facility. On July 20, 2022, at approximately 12;51 p.m., RN-A said the dementia polices had not been passed out to any of the residents. The licensee's 3.00 Assisted Living with Dementia Care Additional Required Policies policy, dated August 1, 2021, indicated additional required polices for dementia care must be provided to residents and the resident's legal and designated representatives at the time of move in. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02110		
02170 SS=F	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs.	02170		

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02170	Continued From page 46 (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have an evaluation for an activity plan for two of two residents (R1, R2) who resided in the dementia-care licensed facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on July 18, 2022,	02170		

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02170	Continued From page 47 at approximately 9:45 a.m., registered nurse (RN)-A stated they provided and were licensed as an assisted living facility with dementia care. R1 R1's diagnoses included epilepsy, insomnia, hypothyroidism, depression, hemiplegia affecting right side, hypertension and esophageal reflux disease. R1's record lacked evidence that the resident had been evaluated for activities according to the licensing rules of the facility, to include the following: - past and current interests; - current abilities and skills; - emotional and social needs and patterns; - physical abilities and limitations; - adaptations necessary for the resident to participate; and - identification of activities for behavioral interventions. In addition, R1's record lacked the development of an individualized activity plan. R2 R2's diagnoses included osteoarthritis, systemic lupus erythematosus (inflammatory disease caused when the immune system attacks its own tissues, often affecting joints, skin, kidneys, heart and lung) and acute kidney failure. R2's record lacked evidence that the resident had been evaluated for activities according to the licensing rules of the facility, to include the following: - past and current interests; - current abilities and skills; - emotional and social needs and patterns;	02170		

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02170	Continued From page 48 - physical abilities and limitations; - adaptations necessary for the resident to participate; and - identification of activities for behavioral interventions. In addition, R2's record lacked the development of an individualized activity plan. On July 20, 2022, at approximately 12:51 p.m., RN-A confirmed activity evaluations were not completed for residents. RN-A said she does ask residents what they like to do and lists out what things they would participate in when she does pre-admission work. RN-A said she would complete a more in-depth review of resident's activity abilities and needs as required and from that create individualized activity plans. The licensee's 3.05 ALDC (assisted living dementia care) Life Enrichment Programs, Activities and Outdoor Space policy dated August 1, 2021, indicated each resident would be evaluated for activities and an individualized activity plan would be developed for each resident based on their activity evaluation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02170		

Minnesota Department of Health

625 Robert Street North
St Paul
651-201-4500

Type: Full
Date: *07/18/22*
Time: 12:08:02
Report: 7994221123

Food and Beverage Establishment Inspection Report

Location:
Epiphany Care Homes Llc
3704 Cardinal Road
Minnetonka, MN55345
Hennepin County, 27

Establishment Info:
ID #: 0038835
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9524758093
ID #:

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

The following orders were issued during this inspection.

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

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

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

RAW EGGS FOUND STORED OVER TOP OF PRODUCE IN THE REFRIGERATOR

Comply By: 07/18/22

4-200 Equipment Design and Construction

4-201.11GMN

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

SEVERAL FOODS FOUND SAVED IN CONTAINERS FOR THE NEXT DAY. ENSURE ALL FOODS ARE ONLY SERVED THE DAY THEY ARE PREPARED.

Comply By: 07/18/22

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

Food and Beverage Establishment Inspection Report

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 7994221123 of 07/18/22.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Inspection report reviewed with person in charge and emailed.

Signed:_____
Establishment Representative

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

Report #: 7994221123

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
625 Robert Street North
St Paul

No. of RF/PHI Categories Out	1	**Date**	07/18/22
No. of Repeat RF/PHI Categories Out	0	**Time In**	12:08:02
Legal Authority MN Rules Chapter 4626		**Time Out**	

Epiphany Care Homes Llc	**Address** 3704 Cardinal Road	**City/State** Minnetonka, MN	**Zip Code** 55345	**Telephone** 9524758093
License/Permit # 0038835	**Permit Holder**	**Purpose of Inspection** Full	**Est Type**	**Risk Category**

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

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

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

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

GOOD RETAIL PRACTICES

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

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

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

			COS	R
		Proper Use of Utensils		
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
		Utensil Equipment and Vending		
47	X	Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48		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:** 07/28/22

Inspector (Signature) Crystal Ehn