Electronically Delivered

February 6, 2025

Licensee
Graceful Lodge Home Care
6430 June Avenue North
Brooklyn Center, MN 55429

RE: Project Number(s) SL35698016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on December 4, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

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

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

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

The correction order documentation should include the following:

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

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

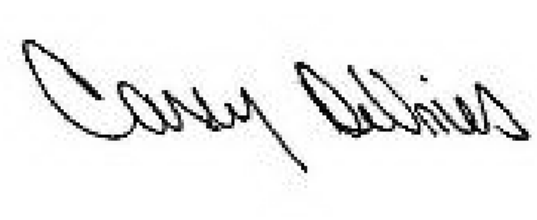
To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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

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

If you have any questions, please contact me.

Sincerely,



Casey DeVries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35698	A. BUILDING: _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACEFUL LODGE HOME CARE	6430 JUNE AVENUE NORTH BROOKLYN CENTER, MN 55429

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0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL35698016-0 On December 2, 2024, to December 4, 2024, the Minnesota Department of Health conducted an initial survey at the above provider, and the following correction are issued. At the time of the survey there were four residents residing at the assisted living facility, all four residents were receiving services under the assisted living 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.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that:	0 470		

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0 470	Continued From page 1 (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 interview and record review, the licensee failed to ensure their staffing plan included a staffing metrics to determine appropriate staffing levels and to update the staffing plan at least twice annually. Further, the licensee failed to post a current staff schedule which had to potential to affect all staff, residents, and volunteers. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 470		

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0 470	Continued From page 2 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's Staffing Plan dated March 2022, was not evaluated or updated at least twice a year for appropriate staffing levels in the facility. Further, it lacked evidence of a staffing metrics used to determine appropriate staffing levels per Minnesota Rules Chapter 4659, 4659.0180 Subpart 3. On December 2, 2024, at 10:15 a.m., during the entrance conference, licensed assisted living director (LALD)-D stated their staffing plan was updated annually, and as needed, by LALD-D and clinical nurse supervisor (CNS)-A. LALD-D stated the daily staffing schedule was posted on a bulletin board in the living room. On December 2, 2024, at 10:39 a.m., during the facility tour with LALD-D and CNS-A, the surveyor observed the licensee's Staffing Plan dated March 2022, and staff schedules posted on the bulletin board in the living room. The surveyor observed three different out-of-date staff schedules posted. The first staff schedule form, untitled, was dated March 21-27, 2022, the second Team Schedule form was dated February 26 to March 3, 2024, and the third Team Schedule form was dated March 4-10, 2024. On December 2, 2024, at 11:14 a.m., CNS-A stated they had not completed a staffing plan	0 470		

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0 470	Continued From page 3 since they were hired by the licensee on November 20, 2023. CNS-A stated the Staffing Plan from March 2022, was the most current staffing plan. On December 2, 2024, at 1:12 p.m., CNS-A stated they were aware staffing schedules were required to be posted. CNS-A stated the posted staff schedules were out of date and the LALD-D was in charge of posting and updating the staff schedules. On December 3, 2024, at 12:31 p.m., LALD-D stated it was their responsibility to post current staff schedules and did not have an explanation as to why the schedules were not up to date. The licensee's Staffing Plan dated March 2022, indicated: "-[Licensee] will maintain three (3) 8-hour shifts: (7:00 am - 3:00 pm, 3:00 pm - 11:00 pm and 11:00 pm - 7:00 am) -There will be a minimum of 1 staff per shift - and an occasional floater as needed. Staff will be awake 24x7 to... -Other staff not on the schedule will be available for ON-CALL DUTIES in case a scheduled employee calls-out due to illness or some other emergency that cannot be immediately remedied. If an ON-CALL person is not available, the administrator who is also trained as a caregiver will provide shift coverage for 8 hours." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		

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0 550	Continued From page 4	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 email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post a notice informing individuals if they have a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints (OHFC) at the Minnesota Department of Health. 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).	0 550		

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0 550	Continued From page 5 The findings include: On December 2, 2024, at 10:39 a.m., during the facility tour with licensed assisted living director (LALD)-D and clinical nurse supervisor (CNS)-A, the surveyor observed the licensee's postings on a bulletin board in the living room. The licensee's postings lacked the required notice directing individuals to the OHFC for complaints about the facility. LALD-D and CNS-A stated they were unaware of what OHFC was and were unaware it was a required posting. The licensee's Grievance policy dated August 1, 2021, indicated: "8. Residents and their families or responsible parties may also complain to the Minnesota Department of Health, Office of Health Facility Complaints at: a. 85 East Seventh Place, Suite 300 b. P.O. Box 64970 c. St. Paul, MN 55164-0970 d. (651) 201-4201." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
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	0 680		

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0 680	Continued From page 6 emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a written emergency preparedness plan (EPP) with all the required content. 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 December 3, 2024, the surveyor reviewed the licensee's Assisted Living Emergency	0 680		

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0 680	Continued From page 7 Preparedness Manual (EPP) last reviewed/updated on March 15, 2024. The EPP lacked evidence of the following required information: - documented risk assessment; - all-hazards approach categorizing the various probably risks/hazards by likelihood of occurrence; - missing resident plan reviewed quarterly; - identify which staff would assume specific roles in another's absence through succession planning and delegation of authority; - identified a qualified person who is authorized in writing to act in the absence of the administrator; - develop policies and procedures (P/P) to address the following whether evacuated or shelter in place for staff/residents: - food, water, medical supplies, pharmaceutical supplies; - EP includes P/P for at minimum food, water, and pharmaceutical supplies; - alternate sources of energy to maintain sewage and waste disposal; - develop P/P for sewage and waste disposal; - evacuation transportation; - evacuation location and arrangement agreement; - develop P/P for system to track the location of on-duty staff and sheltered residents; - develop P/P to address use of volunteers, including the process/role for integration; - develop P/P to address arrangements with other facilities/providers to receive residents in the event of limitations/cessation of operations to maintain the continuity of services to residents; - develop P/P to address role of facility under a waiver declared by the Secretary in accordance with section 1135 of the Act - develop a written communication plan; - communication plan must include:	0 680		

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0 680	Continued From page 8 - method for sharing information and medical documentation for residents under the facility's care, as necessary, with other HCPs to maintain continuity of care; - means, in event of evacuation, to release resident information as permitted under 45 CFR 164.510(b)(1)(ii); and - means of providing information about general condition/ location of residents under the facility's care as permitted under 45 CFR 164.510(b)(4). On December 3, 2024, at 1:03 p.m., licensed assisted living director (LALD)-D stated they did not have an all-hazards risk assessment completed. LALD-D stated they did a partial all hazards risk assessment at some point but did not have one currently. LALD-D stated they had an evacuation location but was not identified in the EPP. LALD-D stated the EPP did not include transportation details; they stated they owned a van for transportation needs but did not include it in the evacuation plan. LALD-D stated the EPP did not address backup food, water and pharmaceutical for shelter in place; they stated they had some dry goods at the facility, but supply needs were not identified in the EPP. LALD-D stated they didn't think sewage disposal was addressed in the EPP. LALD-D stated they didn't realize their EPP lacked required content and would need to address it. The licensee's Emergency Preparedness policy dated August 1, 2021, indicated: "[Licensee] will have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services. The plan considers the organization's commitment to provide services while ensuring	0 680		

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0 680	Continued From page 9 the safety of its employees and residents. [Licensee] will implement the Emergency Management program* as soon as the agency becomes aware of the existence of an emergency." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 800 SS=C	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, 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 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	0 800		

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0 800	Continued From page 10 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 December 4, 2024, from 10:00 a.m. to 12:30 p.m., the surveyor toured the facility with licensed assisted living director (LALD)-D. The following was observed. The window in resident sleeping room 4 did not close and lock. LALD-D opened the window for measurement, but could not get it closed again using the existing hardware. The surveyor went outside to push the window shut which allowed LALD-D to close and lock the window. Egress windows must be provided and properly maintained in buildings not equipped with an automatic sprinkler system. The window screen in resident sleeping room 5 had a large hole. Any operable windows that have a screen installed must maintain the screen in good repair without any tears or punctures. The return/supply grilles located on the kitchen floor were damaged and not the correct size to provide for a smooth transition between the floor and the grilles, creating a dip and tripping hazard for residents and/or staff. The roof soffit material above the electrical meter was falling off of the soffit. On December 4, 2024, at 1:30 p.m. LALD-D stated they will get the above listed deficiencies fixed as soon as possible. TIME PERIOD FOR CORRECTION: Seven (7)	0 800		

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0 800	Continued From page 11 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) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced	0 810		

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GRACEFUL LODGE HOME CARE	6430 JUNE AVENUE NORTH BROOKLYN CENTER, MN 55429

(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
0 810	Continued From page 12 by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content. 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 December 4, 2024, licensed assisted living director (LALD)-D provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, titled "Fire Safety", dated August 1, 2021, 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 provided FSEP was from a third-party provider and had not been updated to the specific facility. 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	0 810		

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0 810	Continued From page 13 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. On December 4, 2024, at 1:30 p.m., LALD-D stated they didn't understand that the third-party policy they were using was not correct. LALD-D stated they would work on bringing them into compliance. The policy reviewed was an unedited policy from a third-party provider that was not specific to the facility. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the	01440		

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01440	Continued From page 14 individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a registered nurse (RN) conducted direct supervision of staff performing a delegated task within 30 days of providing services for two of two employees (unlicensed personnel (ULP)-B, ULP-F). 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: ULP-B ULP-B was hired on August 30, 2022, to provide direct cares to residents. ULP-B's employee record lacked evidence a RN 30-day supervision was completed. ULP-F ULP-F was hired on January 24, 2023, to provide direct cares to residents. ULP-F's employee record lacked evidence a RN 30-day supervision was completed.	01440		

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01440	Continued From page 15 On December 3, 2024, at 10:33 a.m., licensed assisted living director (LALD)-D stated they were not familiar with the RN-30 day supervision since it was the nurse who was supposed to complete them; they stated they would reach out to clinical nurse supervisor (CNS)-A to get the documents for the surveyor. On December 4, 2024, at 11:33 a.m., CNS-A stated they were not employed by the licensee when ULP-B and ULP-F were hired and did not know if they had a RN-30 day supervision completed. CNS-A stated they were aware of the RN-30 day supervision requirement. ULP-B and ULP-F were unavailable for interview. The licensee's Supervision: Unlicensed Staff policy dated August 1, 2021, indicated, "Direct supervision of home health aides performing delegated tasks will be provided within 30 days after the individual begins working for the assisted living provider and thereafter as needed based on performance." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		
01460 SS=D	144G.63 Subdivision 1 Orientation of staff and supervisors (a) All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under	01460		

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01460	Continued From page 16 subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility, except as provided in paragraph (b). (b) A staff person is not required to repeat the orientation required under subdivision 2 if the staff person transfers from one licensed assisted living facility to another facility operated by the same licensee or by a licensee affiliated with the same corporate organization as the licensee of the first facility, or to another facility managed by the same entity managing the first facility. The facility to which the staff person transfers must document that the staff person completed the orientation at the prior facility. The facility to which the staff person transfers must nonetheless provide the transferred staff person with supplemental orientation specific to the facility and document that the supplemental orientation was provided. The supplemental orientation must include the types of assisted living services the staff person will be providing, the facility's category of licensure, and the facility's emergency procedures. A staff person cannot transfer to an assisted living facility with dementia care without satisfying the additional training requirements under section 144G.83. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employees received orientation to assisted living statutes for one of three direct care employees (unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	01460		

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01460	Continued From page 17 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-B was hired on August 30, 2022, to provide direct cares to residents. ULP-B's Educare (online training platform) transcript and employee record lacked orientation training required to be completed by the licensee prior to providing services to residents. Orientation training for handling emergencies and reporting maltreatment was included on the Educare transcript, however it was completed prior to ULP-B's date of hire and was not completed by the licensee. ULP-B lacked evidence of orientation training completed by the licensee for the following topics: - overview of assisted living statutes; - review of provider's policies and procedures; - handling emergencies and using emergency services; - reporting maltreatment of vulnerable adults or minors; - assisted living bill of rights; - handing of resident complaints, reporting of complaints, where to report; - consumer advocacy services; - review of types of assisted living services the employee will provide and provider's scope of license; - principles of person-centered planning/service delivery; - hearing loss training (optional); and - orientation to each specific resident and	01460		

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01460	Continued From page 18 services provided. On December 3, 2024, at 9:46 a.m., licensed assisted living director (LALD)-D (who was also the owner) stated they used Educare for all of their orientation trainings. LALD-D stated ULP-B's orientation training was not conducted by the licensee or within their organization. LALD-D stated the current licensee was the only licensee within their organization. LALD-D stated they thought they could use any previously completed orientation training. LALD-D stated they did not know orientation was not transferable but was good information for them to have to make sure they were completing orientation training correctly. ULP-B was unavailable for interview. The licensee's Staff Orientation and Education policy dated August 1, 2021, indicated: "1. Upon hire and before providing service to residents, all employees attend a general orientation conducted by [licensee]. Those providing direct services will complete a competency evaluation as part of the orientation process.* 2. Orientation is provided by the Clinical Nurse Supervisor or delegate. All clinical topics will be addressed by the RN or other appropriately licensed health care professional. 3. Orientation topics will include, but not be limited to, the following a. Overview of Minnesota Assisted Living Statute 144G and Minnesota Rules Chapter 4659 b. Review of the employee's job description and responsibilities c. Introduction to and review of the organization's policies and procedures related to the provision of assisted living services by the	01460		

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01460	Continued From page 19 individual staff person d. Handling of emergencies and the use of emergency services e. Compliance with Minnesota's Vulnerable Adult (Sections 626.556 and 5572), including requirements based on organizational policy, identification of incidents of maltreatment (abuse, financial exploitation and neglect) and that ay act that constitutes maltreatment is prohibited f. The Assisted Living Bill of Rights and the employee's responsibilities to ensure the exercise and protection of those rights g. The principles of person-centered planning and service delivery and how they apply to direct support services provided by staff h. Grievance Policy/Process, including reports to the Office of Health Facility Complaints i. Consumer advocacy services, including i. Office of Ombudsman for Long-Term-Care ii. Office of Ombudsman for Mental Health and Developmental Disabilities iii. Managed Care Ombudsman at the Department of Human Services iv. County managed care advocates v. Other advocacy services j. The types of assisted living services the employee will be providing based on the Uniform Checklist Disclosure of Services and the organization's category of licensure k. The organizational chart and roles of staff within the facility 4. Orientation may include training on providing services to residents with hearing loss. This training will be research-based and include: a. An explanation of age-related hearing loss and how it manifests itself, its prevalence and the challenges it poses to communication; b. Health impacts related to untreated age-related hearing loss, such as increased	01460		

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01460	Continued From page 20 incidence of dementia, falls, hospitalizations, isolation and depression c. Information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time and closed captions." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01460		
01500 SS=E	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve	01500		

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01500	Continued From page 21 when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employees received at least eight hours of annual training for each 12 months of employment on required annual training topics for two of three employees	01500		

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01500	Continued From page 22 who were employed more than 12 months (unlicensed personnel (ULP)-B, ULP-F). 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-B ULP-B was hired on August 30, 2022, to provide direct cares to residents. ULP-B's Educare (online training platform) transcript and employee record lacked eight hours of annual training to include the following topics: - assisted living bill of rights; - review of policies and procedures; - principles of person-centered planning/service delivery; and - hearing loss training. ULP-F ULP-F was hired on January 24, 2023, to provide direct cares to residents. ULP-F's Educare transcript and employee record lacked eight hours of annual training to include the following topics: - assisted living bill of rights; - infection control techniques; - review of policies and procedures; - principles of person-centered planning/service	01500		

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01500	Continued From page 23 delivery; and - hearing loss training. On December 3, 2024, at 12:31 p.m., licensed assisted living director (LALD)-D stated staff annual training was conducted on the employee's work anniversary in Educare. LALD-D stated they thought all annual trainings were automatically assigned annually by the Educare software; they did not think they had to assign it to the staff member themselves. LALD-D stated they thought ULP-B and ULP-F both had completed their annual training. The licensee's Staff Orientation and Education policy dated August 1, 2021, indicated: "12. All staff providing assisted living services will complete at least eight (8) hours of education for every twelve (12) months of employment. 13. Education topics will include, but not be limited to, the following a. Reporting of maltreatment of adults b. Review of Assisted Living Bill of Rights and staff responsibilities related to ensuring the exercise and protection of those rights c. Review of the organization's policies and procedures related to provision of assisted living services and how to implement them d. Infection control techniques used in the home i. Implementation of infection control standards based on current recommendations per the CDC***** ii. Hand washing techniques iii. Need for/use of personal protective equipment (PPE), including: 1. Gloves 2. Gowns 3. Masks iv. Appropriate disposal of contaminated materials and equipment, such as dressings,	01500		

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01500	Continued From page 24 needles, syringes and razor blades v. Disinfection of reusable equipment vi. Disinfection of environmental surfaces vii. Reporting of communicable diseases e. Effective approaches to use to problem solve when working with a resident's challenging behaviors and how to communicate with residents who have dementia, Alzheimer's Disease or related disorders f. The principles of person-centered planning and service delivery and how they apply to direct support services provided by staff 14. Annual education may include training on providing services to residents with hearing loss. This training will be research-based and include: a. An explanation of age-related hearing loss and how it manifests itself, its prevalence and the challenges it poses to communication; b. Health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation and depression c. Information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time and closed captions." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
01530 SS=D	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements:	01530		

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01530	Continued From page 25 (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide employees with the initial eight (8) hours of dementia training within 160 hours of providing direct care to residents for one of two direct care employees (unlicensed personnel (ULP)-F). 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	01530		

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	35698	A. BUILDING: _____ B. WING _____	12/04/2024

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01530	Continued From page 26 limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-F was hired on January 24, 2023, to provide direct cares to residents. ULP-F's Educare (online training platform) transcript and employee record lacked 8 hours of initial dementia training required within 160 hours of start date for direct-care staff. ULP-F's Educare transcript indicated ULP-F completed 4.75 hours of initial dementia training between August 7, 2024, and August 14, 2024. On December 3, 2024, at 12:31 p.m., licensed assisted living director (LALD)-D stated they used Educare to complete all dementia training. LALD-D stated they thought ULP-F's initial dementia training had been completed. ULP-F was unavailable for interview. The licensee's Dementia Education policy dated August 1, 2021, indicated: "3. Direct care employees must have completed at least eight (8) hours of initial education** within 160 working hours of the employment start date in the following topics: a. An explanation of Alzheimer's Disease and other dementias b. Assistance with activities of daily living (ADL's) c. Problem solving with challenging behaviors d. Communication skills e. Person-centered planning and service delivery."	01530		

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01530	Continued From page 27 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01750 SS=F	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medication orders did not require unlicensed personnel (ULP) to make medication dosage decisions, which was outside of their scope of practice, 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, 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).	01750		

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01750	Continued From page 28 The findings include: R2 R2 was admitted to the licensee on December 22, 2023. R2's Service Plan signed on May 17, 2024, indicated R2 received services for medication administration. R2's Medication -Current list dated December 4, 2024, and Med Admin Summary (MAR) for November 2024, indicated R2 took hydroxyzine pamoate 25 milligram (mg) capsules to take one to two capsules by mouth (PO) every six hours as needed (PRN) for anxiety. R2's MAR for November 2024, indicated the following medication administrations: - hydroxyzine pamoate 25mg capsule; licensed assisted living director (LALD)-D administered one capsule on November 15 and 24; - hydroxyzine pamoate 25mg capsule; unlicensed personnel (ULP)-B administered one capsule on November 22-23, 26 and 28-30; and - hydroxyzine pamoate 25mg capsule; ULP-B administered two capsules on November 19 and 21. On December 3, 2024, at 8:00 a.m., the surveyor observed ULP-C administer medications for R2. R3 R3 was admitted to the licensee on May 25, 2023. R3's Service Plan dated July 22, 2024, indicated R3 received services for medication administration.	01750		

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01750	Continued From page 29 R3 Medications - Current list dated December 3, 2024, and MAR for November 2024, indicated the R3 took the following PRN medications: - acetaminophen 500mg tablet, take one to two tablets (500mg-1000mg) PO every eight hours PRN for mild pain, maximum of 4000mg in 24 hours; and - glucose 15 gel 40%, take 15-30 grams (g) PO every 15 minutes PRN for low blood sugar. On December 3, 2024, at 9:11 a.m., the surveyor observed ULP-C administer medications for R3. On December 2, 2024, at 10:15 a.m., during the entrance conference, clinical nurse supervisor (CNS)-A and LALD-D stated ULPs were allowed to give PRN medication independently without contacting the nurse. On December 3, 2024, at 12:31 p.m., LALD-D stated they were trained on medication administration by their previous CNS. On December 4, 2024, at 11:33 a.m., CNS-A stated they (CNS-A) were not employed by the licensee at the time of LALD-D and ULP-B's training; it was completed by the previous CNS. CNS-A stated they had done random supervisions with LALD-D and ULP-B. CNS-A stated they were aware PRN medication should not have a dose range which would require ULP to make clinical decisions. CNS-A stated ULPs were required to call the nurse to figure out what dose to give. The surveyor explained, during the entrance conference, both CNS-A and LALD-D stated ULPs could administer PRN medication independently without contacting the nurse. CNS-A stated, "oh, yeah." No further information was provided.	01750		

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01750	Continued From page 30 TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure staff verified and documented medication administration 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).	01760		

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01760	Continued From page 31 The findings include: R2 was admitted to the licensee on December 22, 2023. R2's Service Plan signed on May 17, 2024, indicated R2 received services for medication administration. R2's prescriber orders, signed by R2's provider on December 27, 2023, indicated R2 took the following medications: - Flovent (fluticasone) HFA 44 micrograms (mcg) inhaler, inhale two puffs PO twice daily. R2's Medication -Current list dated December 4, 2024, indicated R2 took the following medications: - fluticasone Nasal Spray-50mcg, instill 2 sprays in each nostril once daily; lacked a provider order. R2's Med Admin Summary (MAR) for November 2024, indicated the following medications were put on hold on November 5, 2024, but lacked a hold order from R2's provider: - Flovent (fluticasone) HFA 44mcg inhaler, inhale two puffs PO twice daily; and - fluticasone Nasal Spray-50mcg, instill 2 sprays in each nostril once daily. On December 2, 2024, at 12:55 p.m., clinical nurse supervisor (CNS)-A stated they put R2's fluticasone nasal spray and fluticasone inhaler on hold because R2 was refusing both medications. On December 3, 2024, at 12:31 p.m., the surveyor observed R2 request their fluticasone nasal spray from licensed assisted living director (LALD)-D who then administered it to R2. LALD-D did not review R2's MAR or fluticasone	01760		

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01760	Continued From page 32 nasal spray prescription label to ensure the correct medication was administered to R2. LALD-D stated they did not check R2's MAR, prescription label, and did not document the medication administration in R2's MAR. LALD-D stated they were aware the medication had been put on hold by CNS-A, but they knew R2 needed it. On December 4, 2024, at 11:33 a.m., CNS-A stated they used their own judgement to put R2's fluticasone nasal spray-50mcg and fluticasone inhaler-44mcg on hold; they stated they should have contacted R2's provider. CNS-A stated they reactivated R2's fluticasone nasal spray 50mcg and fluticasone inhaler 44mcg during the survey(December 4, 2024); they stated they messaged R2's provider about both medications but had not yet heard back from them. The licensee's Medication Documentation policy dated August 1, 2021, indicated, "Each medication administered by [licensee] staff will be documented in the resident ' s clinical record. Documentation will be complete, accurate and legible." It also indicated, "Documentation of medication administration and medication set up will be completed promptly." Additionally, it indicated: "Complete documentation of medication administration includes the following: a. Resident ' s name b. Medication name c. Medication dosage d. Date and time of administration e. Method/route of administration f. Signature and Title of staff administering the medication." No further information was provided.	01760		

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01760	Continued From page 33 TIME PERIOD FOR CORRECTION: Two (2) days	01760		
01820 SS=F	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure written or electronically recorded prescriptions were obtained for 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 the licensee on December 22, 2023. R2's Service Plan signed on May 17, 2024, indicated R2 received services for medication administration. R2's prescriber orders, signed by R2's provider	01820		

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01820	Continued From page 34 on December 27, 2023, indicated R2 took the following medications: - aripiprazole 10 milligrams (mg), take one tablet by mouth (PO) once daily; - Flovent (fluticasone) HFA 44 micrograms (mcg) inhaler, inhale two puffs PO twice daily; and - tamsulosin 0.4 mg capsule, take one capsule PO daily. R2's Medication -Current list dated December 4, 2024, indicated R2 took the following medications: - Aripiprazole 15 mg tablet, take one tablet PO daily; 5 mg more than the above signed orders; - Benztropine 0.5 mg tablet; take one tablet PO daily; lacked a provider order; - fluticasone Nasal Spray-50 mcg 12/03/24, instill 2 sprays in each nostril once daily; lacked a provider order; - cyclobenzaprine 10 mg tablet, take one tablet PO up to 3 times per day as needed (PRN) for muscle spasms; lacked a provider order; - Hydroxyzine Pamoate 25 mg capsules, take one to two capsules PO every six hours PRN for anxiety; lacked a provider order; - Quetiapine 25 mg tablet, take one tablet PO once daily PRN for agitation; lacked a provider order; and - triamcinolone Cream 0.1%, apply topically to skin twice daily, use until patch on left shin goes away, lacked a provider order; medication on hold. R2's Med Admin Summary (MAR) for November 2024, indicated the following medications were put on hold as of November 5, 2024, but lacked a hold order from R2's provider: - Flovent (fluticasone) HFA 44 mcg inhaler, inhale two puffs PO twice daily; and - fluticasone Nasal Spray-50 mcg, instill 2 sprays	01820		

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01820	Continued From page 35 in each nostril once daily. On December 2, 2024, at 12:55 p.m., the surveyor explained to clinical nurse supervisor (CNS)-A the medication orders for R2 did not match R2's current medication list and MAR for November 2024. CNS-A stated they should have additional orders which would account for the differences and would provide them. CNS-A stated they put R2's fluticasone nasal spray 50 mcg and fluticasone inhaler 44 mcg on hold because R2 was refusing both medications; they stated they did not have a prescribers order to put the medications on hold. CNS-A stated they did not know they needed an order to put a medication on hold. On December 3, 2024, at 8:00 a.m., the surveyor observed unlicensed personnel (ULP)-C administer medications for R2. On December 4, 2024, at 11:33 a.m., CNS-A stated they were working on a better system for managing prescriptions with the pharmacy. CNS-A stated they used their own judgement to put R2's fluticasone nasal spray 50 mcg and fluticasone inhaler 44 mcg on hold; they stated they should have contacted the provider. CNS-A stated R2 was a resident who wanted to be as independent as they could and often didn't always share clinic appointment information with them. CNS-A stated they reactivated R2's fluticasone nasal spray 50 mcg and fluticasone inhaler 44 mcg during the survey (December 4, 2024); they stated they messaged R2's provider about both medications but had not yet heard back from them. CNS-A stated they were unaware there was a conflict between R2's prescriber orders and R3's MAR for November 2024, and would need to double check their orders.	01820		

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01820	Continued From page 36 No further prescriptions were provided for R2. R3 R3 was admitted to the licensee on May 25, 2023. R3's Service Plan dated July 22, 2024, indicated R3 received services for medication administration. R3 Medications - Current list dated December 3, 2024, and MAR for November 2024, indicated the R3 took the following medications but all lacked a provider order: - diazepam 5 milligram (mg) tablets, take one tablet PO once 30 minutes before a magnetic resonance imaging (MRI); - esomeprazole 40 mg capsule, take one capsule PO every morning 30-60 minutes before eating; - hydrocortisone Cream 1%, apply topically to affected area twice daily; - lidocaine 5% patch, apply one patch topically every 24 hours apply at 8:00 a.m. and remove at 8:00 p.m.; - mirtazapine 30 mg tablet, take one tablet PO at bedtime; - olanzapine 2.5 mg, take one tablet PO; - olanzapine 5 mg tablet, take one tablet PO three times daily PRN for agitation/anxiety; - olanzapine 10 mg tablet, take one tablet PO at bedtime; - ondansetron 4 mg tablet, take one tablet PO every eight hours PRN for nausea; - orphenadrine 100 mg ER, take one tablet PO daily PRN for muscle spasms; - phenazopyridine 100 mg tablet; take one tablet PO three times daily PRN for urinary tract discomfort; - Qc Cough Relief liquid 15 mg/5 ml, take 5 ml	01820		

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01820	Continued From page 37 (15 mg) PO four times daily PRN for cough; - tizanidine 2 mg tablet; take one tablet PO three times daily PRN for muscle spasms; and - timolol maleate solution 0.5% optical, instill one drop in both eyes twice daily; R3's Interagency Transfer Orders signed March 5, 2024, indicated R3 was prescribed the following medications which were not on R3's MAR November 2024: - ipratropium-albuterol 20-100 mcg/actuation, inhale one puff four times a day; - lidocaine cream 4-1% gel; apply topically twice a day PRN; - methotrexate 2.5 mg tablet, take 10 mg PO every Sunday; - nabumetone 500 mg tablet, oral; lacked further instruction; - paliperidone 6 mg Tr24; take PO daily; - RABEprazole 20 mg delayed release tablet, take 20 mg PO daily; and - senna 8.6 mg tablet, take PO every evening. R3's Interagency Transfer Orders signed March 5, 2024, and MAR November 2024 did not match: - olanzapine 2.5 mg tablet, take 2.5 mg PO every six hours PRN was on the prescriber orders; olanzapine 2.5 mg tablet, take one tablet PO daily was on the MAR and did not match the prescribers orders; - buspirone 15 mg tablet, take 15 mg PO three times daily was on the prescriber orders; buspirone 10 mg tablet, take two tablets (20 mg) three times daily for anxiety was on the MAR and did not match the prescribers orders; - lamotrigine 25 mg tablet, take 50 mg PO twice daily was on the prescriber orders; lamotrigine 150 mg tablet, take one tablet PO twice daily was on the MAR and did not match the prescribers orders;	01820		

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01820	Continued From page 38 - levothyroxine 100 mcg tablet, take one tablet daily at 6:00 a.m. was on the prescriber orders; levothyroxine 75 mcg tablet, take one tablet PO daily was on the MAR and did not match the prescribers orders; and - nystatin 100,000 unit/gram (g) powder, apply topically twice a day was on the prescriber orders; nystatin powder 60 g, apply topically to affected area PRN up to two times a day, was on the MAR and did not match the prescribers orders. R3's Medication List signed (during the survey) on December 3, 2024, indicated the following: - apremilast 10, 20, and 30mg tables, take 1 tablet in the morning on day one, then take one tablet every 12 hours thereafter, according to the packet instructions; this order was not on the above-mentioned prescriber orders or MAR; - Aquaphor, apply topically daily; this was not on the above-mentioned prescriber orders or MAR; - buspirone hydrochloride (HCL) 10mg tablets, take one tablet PO three times daily, this did not match the above-mentioned prescriber orders or MAR ; - dextromethorphan quinidine 20-10mg capsule, take one capsule PO daily; this order was not on the above-mentioned prescriber orders or MAR; - diazepam 5 milligram (mg) tablets, take one tablet PO once 30 minutes before a magnetic resonance imaging (MRI), this was not on the above-mentioned prescriber orders or MAR; - esomeprazole 40mg capsule, take one capsule PO every morning 30-60 minutes before eating, this was not on the above-mentioned prescriber orders; - hydrocortisone 1% cream, apply topically 2 times daily; this order was not on the above-mentioned prescriber order; - hydroxyzine HCL 50mg tablet, take one tablet PO three times daily PRN; this order was not on	01820		

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	35698	A. BUILDING: _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACEFUL LODGE HOME CARE	6430 JUNE AVENUE NORTH BROOKLYN CENTER, MN 55429

(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 39 the above -mentioned orders or MAR; - ibuprofen 200mg tablet; take 200-400mg PO every eight hours PRN for pain; this order was not on the above-mentioned orders or MAR; - lamotrigine 150mg tablet, take 150mg tablet PO twice daily; the above-mentioned order and MAR did not match; - levothyroxine sodium 75mcg take one tablet PO daily; did not match the above-mentioned prescriber orders; - lidocaine 5% patch, apply one patch topically every 24 hours apply at 8:00 a.m. and remove at 8:00 p.m., this was not on the above-mentioned prescriber orders; - mirtazapine 30mg tablet, take one tablet PO at bedtime, this was not on the above-mentioned prescriber orders; - olanzapine 2.5mg, take one tablet PO, this was not on the above-mentioned prescriber orders; - olanzapine 5mg tablet, take one tablet PO three times daily PRN for agitation/anxiety, this was not on the above-mentioned prescriber orders or MAR; - olanzapine 10mg tablet, take one tablet PO at bedtime, this was not on the above-mentioned prescriber orders or MAR; - ondansetron 4mg tablet, take one tablet PO every eight hours PRN for nausea, this was not on the above-mentioned prescriber orders; - orphenadrine citrate 100mg tablet, take one tablet PO two times daily PRN for muscle spasms, this was not on the above-mentioned prescriber orders or MAR; - RABEprazole 20 mg delayed release tablet, take 20mg PO daily, this was not on the above-mentioned MAR; - sennosides 8.6mg tablet, take one tablet PO twice daily, this was not on the above-mentioned prescriber orders; - tizanidine 2mg tablet; take one tablet PO three	01820		

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01820	Continued From page 40 times daily PRN for muscle spasms, this was not on the above-mentioned prescriber orders; and - timolol maleate solution 0.5% optical, instill one drop in both eyes twice daily, this was not on the above-mentioned prescriber orders or MAR. On December 3, 2024, at 9:11 a.m., the surveyor observed ULP-C administer medications for R3. On December 3, 2024, at 1:03 p.m., the survey explained R3's medication orders did not match R3's MAR for November 2024. LALD-D stated they would contact R3's clinic to see if they could get updated medication orders. On December 4, 2024, at 11:33 a.m., CNS-A stated they were working on a better system for managing prescriptions with the pharmacy. CNS-A stated they were unaware there was a conflict between R3's prescriber orders and R3's MAR for November 2024, and would need to double check their orders. The licensee's Medication Orders policy dated August 1, 2021, indicated. "[Licensee] will maintain a current written or electronically recorded prescription for all prescribed medications managed for the resident." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
01880 SS=D	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments	01880		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01880	Continued From page 41 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 prescription medication securely to permit only authorized personnel to have access for one of one resident (R3) with refrigerated medications. 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: R3 was admitted to the licensee on May 25, 2023. R3's Service Plan dated July 22, 2024, indicated R3 received services for medication administration. R3's Medications - Current form dated December 3, 2024, indicated R3 took the following medications: - Humulin N KwikPen insulin, 100 units (u)/milliliter (ml) give 10u subcutaneously (SQ) twice daily for diabetes; - insulin aspart injection FlexPen, inject 5-10u SQ three times daily with meals, use 5u if blood glucose (BG) is less than 300, use 10u if BG is less than 400 for diabetes; and	01880		

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01880	Continued From page 42 - timolol maleate ophthalmic solution 0.5%, instill one drop in both eyes twice daily for eye pressure. On December 2, 2024, at 11:23 a.m., the surveyor observed and reviewed the contents of the facility medication refrigerator in the dining room with clinical nurse supervisor (CNS)-A; the refrigerator lacked a locking mechanism to allow only authorized personnel access to the medications. The surveyor stated the refrigerator lacked a locking mechanism; CNS-A stated, "you're right, I didn't notice that." CNS-A stated they would need to get a lock for the refrigerator. The surveyor observed the following medications for R3 stored in the medication refrigerator: - Humulin N KwikPen insulin, two pens; - insulin aspart injection FlexPen, two pens; and - timolol maleate ophthalmic solution 0.5%, two bottles. On December 3, 2024, at 8:00 a.m., the surveyor observed unlicensed personnel (ULP)-C administer the following medications to R3: - Humulin N KwikPen insulin; and - insulin aspart injection FlexPen. The licensee's Storage/Control of Medications policy dated August 1, 2021, indicated, "When Graceful Lodge Home Care is providing storage of medications outside of the resident's private living space, all prescription drugs are securely locked in substantially constructed compartments according to the manufacturer's directions. Only authorized personnel have access to the stored medications." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	01880		

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01880	Continued From page 43 days	01880		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were labeled with an opened-on date for one of one resident (R3) with insulin. 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: R3 was admitted to the licensee on May 25, 2023. R3's Service Plan dated July 22, 2024, indicated R3 received services for medication administration. R3's Medications - Current form dated December	01890		

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01890	Continued From page 44 3, 2024, indicated R3 took the following medications: - Humulin N KwikPen insulin, 100 units (u)/milliliter (ml) give 10u subcutaneously (SQ) twice daily for diabetes; and - insulin aspart injection FlexPen, inject 5-10u SQ three times daily with meals, use 5u if blood glucose (BG) is less than 300, use 10u if BG is less than 400 for diabetes. On December 3, 2024, at 8:00 a.m., the surveyor observed unlicensed personnel (ULP)-C administer the following insulins to R3; both insulin pens lacked opened-on date labeling: - Humulin N KwikPen insulin; and - insulin aspart injection FlexPen. On December 3, 2024, at 8:05 a.m., licensed assisted living director (LALD)-D and ULP-C stated they were aware insulin pens could only be used for so many days after opening; both stated R3's insulin pens lacked opened-on dates. LALD-D inquired from the surveyor what kind of labels they could use to label the insulin pens with opened-on dates. On December 3, 2024, at 8:25 a.m., ULP-C stated they were trained to label insulin pens with opened-dates. ULP-C stated it was the responsibility of whomever opens an insulin pen to label it with an opened-on date. On December 3, 2024, at 11:33 a.m., clinical nurse supervisor (CNS)-A stated their expectation was for insulin pens to be labeled with an opened-on date by the person who opened the insulin pen. CNS-A stated they trained staff to label insulin pens with opened on dates. CNS-A stated they performed audits of medication storage bins on a regular basis and didn't notice	01890		

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01890	Continued From page 45 R3's insulin pens were not labeled. The manufacturer instructions for Humulin N KwikPen insulin, revised in June 2022, indicated to throw away in-use insulin pens after 14 days even if it still has insulin left in it. The manufacturer instructions for insulin aspart FlexPen, revised in February 2023, indicated to throw away in-use insulin pens after 28 days even if it still has insluin left in it. The licensee's Storage/Control of Medications policy dated August 1, 2021, indicated, "The licensed nurse is responsible for dating time-sensitive medications when opened." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure clinical nurse supervisor (CNS)-A practiced within their registered nurse (RN) scope of practice when	02320		

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02320	Continued From page 46 they put medications on hold without a provider order 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: CNS-A was hired by the licensee on November 20, 2023, to provide direct cares to residents. CNS-A's Job Description: Registered Nurse position summary signed on November 16, 2023, indicated, "Provides services to clients in accordance with the state Nurse Practice Act, agency policy and accepted professional standards of practice. The Registered Nurse provides nursing services utilizing a comprehensive base of nursing theory and nursing process and communicates/documents observations and assessments." The surveyor reviewed CNS-A's nursing license on the Minnesota Board of Nursing website December 2, 2024, which indicated CNS-A was a RN but was not an advanced practice RN. R2 R2 was admitted to the licensee on December 22, 2023. R2's Service Plan signed on May 17, 2024, indicated R2 received services for medication	02320		

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02320	Continued From page 47 administration. R2's prescriber orders, signed by R2's provider on December 27, 2023, indicated R2 took the following medications: - Flovent (fluticasone) HFA 44 micrograms (mcg) inhaler, inhale two puffs PO twice daily. R2's Medication -Current list dated December 4, 2024, indicated R2's took the following medications: - fluticasone Nasal Spray-50 mcg, instill 2 sprays in each nostril once daily; lacked a provider order. R2's MAR for November 2024, indicated the following medications were put on hold on November 5, 2024, but lacked a hold order from R2's provider: - Flovent (fluticasone) HFA 44 micrograms (mcg) inhaler, inhale two puffs PO twice daily; and - fluticasone Nasal Spray-50 mcg, instill 2 sprays in each nostril once daily. On December 2, 2024, at 12:55 p.m., CNS-A stated they put R2's fluticasone nasal spray 50 mcg and fluticasone inhaler 44 mcg on hold because R2 was refusing both medications; they stated they did not have a prescriber's order to put the medications on hold. CNS-A stated they did not know they needed an order to put a medication on hold. On December 3, 2024, at 12:31 p.m., the surveyor observed R2 request their fluticasone nasal spray from licensed assisted living director (LALD)-D who then administered it to R2. LALD-D did not review R2's MAR or fluticasone nasal spray prescription label to ensure the correct medication was administered to R2. LALD-D stated they did not check R2's MAR,	02320		

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02320	Continued From page 48 prescription label, and did not document the medication administration in R2's MAR. LALD-D stated they were aware the medication had been put on hold by CNS-A, but they knew R2 needed it. On December 4, 2024, at 11:33 a.m., CNS-A stated they used their own judgement to put R2's fluticasone nasal spray-50 mcg and fluticasone inhaler-44 mcg on hold and should have contacted R2's provider to obtain an order. CNS-A stated they reactivated R2's fluticasone nasal spray 50 mcg and fluticasone inhaler 44 mcg during the survey (December 4, 2024); they messaged R2's provider about both medications but had not yet heard back from them. The licensee's Medication Orders policy dated August 1, 2021, indicated, "[Licensee] will administer medications as prescribed by the authorized prescriber. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		

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

Type: Full
Date: *12/02/24*
Time: 12:00:00
Report: 1005241313

Food and Beverage Establishment Inspection Report

Location:
Graceful Lodge Home Care
6430 June Avenue North
Brooklyn Center, MN55429
Hennepin County, 27

Establishment Info:
ID #: 0039305
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7636570611
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.

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Utensil Surface Temp.: = at 160+ Degrees Fahrenheit
Location: DISHWASHER
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Hold/MILK
Temperature: 37 Degrees Fahrenheit - Location: KITCHEN REFRIGERATOR
Violation Issued: No

Process/Item: Cold Hold/SOUR CREAM
Temperature: 39 Degrees Fahrenheit - Location: KITCHEN REFRIGERATOR
Violation Issued: No

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

INSPECTION COMPLETED WITH DIRECTOR AND REVIEWED WITH HRD NURSING EVALUATOR JOEY KEEN.

SINGLE-USE TEMPERATURE STRIPS FOR THE DISHWASHER WERE ON SITE. THE DISHWASHER IS TESTED ALMOST DAILY AND A LOG IS KEPT, WHICH SHOWS THE DISHWASHER IS PROVIDING A UTENSIL SURFACE TEMPERATURE OF AT LEAST 160 DEGREES F.

DISCUSSED DATE MARKING, GLOVE USE, COOKING TEMPERATURES, CROSS-CONTAMINATION, AND EMPLOYEE ILLNESS.

KITCHEN IS RESIDENTIAL AND FOOD IS PREPARED FOR SAME DAY SERVICE.

Food and Beverage Establishment Inspection Report

FLOORING IS WOOD, CABINETS ARE WOOD WITH HOLLOW BASE, AND COUNTERS ARE LAMINATE. ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT SUCH A TIME THEY ARE FOUND TO BE A CONCERN OR RISK OF CONTAMINATION, THEY WILL BE ORDERED TO BE REPLACED AND BROUGHT UP TO CODE.

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 1005241313 of 12/02/24.

Certified Food Protection Manager: DANIEL S. BREWER

Certification Number: FM110679 Expires: 04/21/25

Inspection report reviewed with person in charge and emailed.

Signed: _____

DANIEL BREWER
HOUSING DIRECTOR

Signed: _____

Jessica Davis
Public Health Sanitarian III
651-201-3961
jessica.davis@state.mn.us