Electronically Delivered

August 25, 2022

Administrator
Suite Living Senior Care Of Vadnais
580 Liberty Way
Vadnais Heights, MN 55127

RE: Project Number(s) SL33260015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on July 28, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

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

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

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

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

The total amount you are assessed is $500.00. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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

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

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both.

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

Sincerely,

Jonathan Hill, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jonathan.hill@state.mn.us
Telephone: 651-592-5119 Fax: 651-215-9697

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33260	A. BUILDING: _____ B. WING _____	07/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUITE LIVING SENIOR CARE OF VA	580 LIBERTY WAY VADNAIS HEIGHTS, MN 55127

(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: SL33260015 On July 25 through July 28, 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 28 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.	
0 430 SS=C	144G.40 Subd. 2 Uniform checklist disclosure of services	0 430		

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0 430	Continued From page 1 (a) All assisted living facilities must provide to prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a). This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a copy of the Uniform Checklist Disclosure of Assisted Living Services and Amenities (UDALSA) with the required content for three of three residents (R1, R2, R3) with records reviewed. This affected all residents admitted to the facility prior to August 1, 2021. 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).	0 430		

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0 430	Continued From page 2 The findings include: The licensee converted to an Assisted Living with Dementia Care license on August 1, 2021. R1 R1 was admitted October 29, 2020, and began receiving services under the assisted living license on August 1, 2021. R1's service plan, dated October 29, 2020, indicated she received services which included assistance with medication management, meals, housekeeping, laundry, diabetic management, and activities of daily living (ADLs). R2 R2 was admitted December 27, 2018, and began receiving services under the assisted living license on August 1, 2021. R2's service plan, dated December 27, 2019, indicated she received services which included assistance with medication management, meals, housekeeping, laundry, diabetic management, and ADLs. R3 R3 was admitted April 17, 2020, and began receiving services under the assisted living license on August 1, 2021. R3's service plan, dated April 17, 2020, indicated she received services which included assistance with medication management, meals, housekeeping, laundry, and ADLs. R1, R2, and R3's records lacked evidence of a signature from the resident or resident	0 430		

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0 430	Continued From page 3 representative indicating that a UDALSA had been provided, to include: - a disclosure of the categories of assisted living licenses available and the category of license held by the facility; - a written checklist listing all services permitted under the facility's license identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and -an oral explanation of the services offered under the contract. On July 26, 2022, at 11:13 a.m., licensed assisted living director (LALD)-I stated R1, R2, R3 did not have the UDALSA because they moved in prior to the change in statute requirements on August 1, 2021. LALD-I stated the UDALSA was provided to all residents admitted after August 1, 2021. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 430		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply:	0 480		

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0 480	Continued From page 4 (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, Minnesota Rules, chapter 4626. This had the potential to affect all 28 residents 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: Please refer to the included document titled, Food and Beverage Establishment Inspection Report, dated July 25, 2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 485 SS=C	144G.41 Subd 1. (13) (i) (A) and (C) Minimum Requirements	0 485		

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0 485	Continued From page 5 (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (A) menus must be prepared at least one week in advance, and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; (C) the facility cannot require a resident to include and pay for meals in their contract; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the Assisted Living contract did not require any resident to include and pay for meals as a part of their assisted living package fee for 3 of 3 residents with records reviewed. This had the potential to affect all 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	0 485		

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0 485	Continued From page 6 the residents). The findings include: The licensee converted to an Assisted Living with Dementia Care license on August 1, 2021. R1 was admitted October 30, 2020, and began receiving services under the assisted living license August 1, 2021. R2 was admitted December 27, 2018, and began receiving services under the assisted living license August 1, 2021. R3 was admitted April 17, 2020, and began receiving services under the assisted living license August 1, 2021. R1, R2, and R3's service agreements, dated October 30, 2020, December 27, 2019, and April 17, 2020, respectively, all indicated the resident received services to include 3 meals and 2 snacks per day, with the fee indicated: "included in rent". The resident contract utilized for residents admitted prior to August 1, 2021, indicated, "Residents in Memory Care must purchase one of the Memory Care Packages as outlined in Attachment A, and residents in Assisted Living must purchase one of the Additional Required Service packages outlined in Attachment A, as a condition of residency in the Facility, even if Resident chooses not receive all or any of the services included in those packages". The resident contract utilized for admissions after August 1, 2021, indicated, "Beginning with the Date of Possession, Management will provide	0 485		

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0 485	Continued From page 7 Resident with the Basic Features and Services listed in Attachment B, all of which are included in the initial monthly rent as defined on the attached Data Sheet. The Basic Features and Services for residents in Memory Care include a service package." The contract further indicated, "Even if Resident chooses to receive services from other agencies, as a condition of residency in Facility, Resident must nevertheless pay for one of the Memory Care Packages outlined in Attachment B or one of the Assisted Living Packages outlined in Attachment B, as a condition of residency. " The referenced attachments were not provided. On July 26, 2022, at 4:05 p.m., licensed assisted living director (LALD)-I verified all residents admitted before August 1, 2021, used the previous contract, and all residents admitted after August 1, 2021, were provided the new version of the contract. On July 27, 2022, at 11:04 a.m., registered nurse (RN)-D stated resident meals were included in their rent and a resident would pay for it regardless if they wanted the meals or not. RN-D added alternative meal options would be provided if a resident did not want the meal served. On July 27, 2022, at 11:09 a.m., LALD-B stated the facility used "all-inclusive pricing". LALD-I further stated meals and snacks are included in the package with no "opt-out" option. LALD-I indicated residents would occasionally refuse the meal as served, and in those cases, an alternative would be offered. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 485		

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0 485	Continued From page 8 (21) days	0 485		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program to comply with accepted health care, medical, and nursing standards for infection control and current recommendations for COVID-19. The licensee failed to ensure shared medical equipment was disinfected between use with residents. This had the potential to affect all residents in the unsecured assisted living unit receiving assistance with blood glucose monitoring. Further, the licensee failed to ensure appropriate personal protective equipment (PPE) was worn in the facility and while providing cares. This had the potential to affect all twenty-eight (28) residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 510		

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0 510	Continued From page 9	0 510		

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:

COVID PPE
Unlicensed personnel (ULP)-F was hired February 28, 2022, and provided direct care services for the licensee's residents.

ULP-E was hired August 8, 2017, and provided direct care services for the licensee's residents.

ULP-B was hired July 3, 2019, and provided direct care services for the licensee's residents.

Activities director (AD)-G was hired January 7, 2022, and provided activities services for the licensee's residents.

On July 26, 2022, at 8:16 a.m., ULP-F was observed without eye protection and face mask below her nose while wheeling an unidentified resident in a wheelchair (w/c).

On July 26, 2022, at approximately 11:29 a.m., ULP-E and ULP-F were observed without eye protection and face mask below their nose while transferring two unidentified residents from a couch into their w/c with a transfer belt.

On July 26, 2022, at 11:30 a.m., during treatment and medication administration observation, ULP-B was observed to be wearing a facemask, but lacked appropriate eye protection, wearing

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0 510	Continued From page 10	0 510		

only personal prescription eyeglasses, while performing blood glucose monitoring and administering medications to residents R1 and R2.

On July 26, 2022, at 11:48 a.m., ULP-B stated she wore a mask while working but added staff was not required to wear eye protection since COVID had, "slowed down." ULP-B further stated she was unsure when her last infection control training was.

On July 26, 2022, at 11:51 a.m., ULP-E and ULP-F were observed passing meal trays in the main dining room with residents present. ULP-F was wearing her mask below her nose without eye protection. ULP-E was wearing her mask appropriately but was not wearing eye protection.

On July 26, 2022, at 12:00 p.m., AD-G was observed passing meal trays in the main dining room with residents present. AD-G was wearing a face mask below her nose and lacked eye protection.

On July 26, 2022, at 1:30 p.m., registered nurse (RN)-A verified staff are required to wear a facemask while in the facility. RN-A indicated they received information from the Minnesota Department of Health (MDH), possibly during a webinar, that indicated eye protection requirements had been discontinued.

CLEANING OF SHARED EQUIPMENT
R1
R1 was admitted October 29, 2020, and began receiving services under the assisted living license on August 1, 2021. R1 had diagnoses including diabetes type II and required daily blood glucose (BG) monitoring.

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0 510	Continued From page 11 R1's service plan, dated October 29, 2020, indicated she received services including assistance with diabetic management to include blood glucose checks. R2 R2 was admitted December 27, 2018, and began receiving services under the assisted living license on August 1, 2021. R2's service plan, dated December 27, 2019, indicated she received services including assistance with diabetic management to include blood glucose checks. On July 26, 2022, at approximately 11:30 a.m., during a treatment and medication administration observation, ULP-B was observed to assist R1 and R2 with blood glucose monitoring. ULP-B failed to clean or disinfect a shared glucometer (blood glucose monitor) between use for R1 and for R2. On July 26, 2022, at 11:46 a.m., ULP-B acknowledged she did not clean the glucometer after use for R2, prior to use for R1. ULP-B stated the glucometer is shared between all residents receiving assistance with blood glucose monitoring in the unsecured assisted living unit. ULP-B further stated she did not know she was supposed to clean the glucometer. On July 27, 2022, at 7:26 a.m., RN-D stated glucometers should always be disinfected between uses. The licensee's COVID Infection Control policy, dated March, 2021, indicated all staff would receive training and demonstrate understanding	0 510		

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	33260	A. BUILDING: _____ B. WING _____	07/28/2022

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0 510	Continued From page 12 of when to use PPE. The Minnesota Department of Health COVID-19 Personal Protective Equipment (PPE) Grid for Congregate Care Settings dated April 7, 2022, instructed health care workers (HCW) with face-to-face contact with COVID-19 negative residents to wear a medical grade well-fitting facemask and eye protection. In addition, it instructed HCW with no face-to-face contact with residents to wear a medical-grade well-fitting facemask. The Minnesota Department of Health (MDH) guidance titled, "COVID-19 PPE and Source Control Grids - for congregate care settings, by community transmission level", dated July 25, 2022, July 26, 2022, and July 27, 2022 indicated during "substantial" or "high" levels of community transmission (based on the Centers for Disease Control and Prevention (CDC) online data tracking system), caregivers must wear a face mask (source control) and eye protection while working with residents without suspected or confirmed SARS-CoV-2 infection. The CDC COVID Data Tracker on July 25, 2022, July 26, 2022, and July 27, 2022, indicated Ramsey County, MN (the county of the assisted living facility) was at a "high" level of community transmission, which indicated the use of a face mask and eye protection while working with residents. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 510		

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0 680	Continued From page 13	0 680		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing 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 develop a written emergency preparedness (EP) plan with all the required content. This had the potential to affect all twenty-eight (28) residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 680		

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0 680	Continued From page 14 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 July 27, 2022, the licensee-provided "[Licensee] Emergency Handbook", dated on a future date of 7/2023, and "[Licensee] Accident in the Workplace and Injury Reduction (AWAIR) Program handbook", undated, were both reviewed and noted to lack required information and customization to the facility. The provided EP plan lacked individualized emergency procedures to include the following: - annual policy reviews; - annual reviews of EP plan; - arrangements/contracts to re-establish utility services; - an assessment of the at-risk population's needs; - a process for emergency preparedness cooperation with state and local EP officials/organizations; - a tracking system used to document locations of residents and staff; - the medical record documentation system to preserve resident information; - means of releasing and providing resident information in the event of an evacuation; - means to providing information about the facility's occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee; - identify which staff would assume specific roles	0 680		

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0 680	Continued From page 15 and in another staff members absence; - handling and use of volunteers; - plan to address food, water, and pharmaceutical supplies; - alternate sources of emergency and standby power systems to help maintain safe temperature, sanitation, emergency lighting, fire detection, sewage; - include a process for cooperating and collaboration with local tribal, regional, state and federal EP to maintain integrated response; - EP training and testing program; - conducting exercises to test the EP at least twice per year; - how the facility would operate under an 1135 waiver; - a written communication plan that included: - names and contact information for staff, resident physicians, other facilities; and - a method of sharing information and medical documentation for residents. - contact information for Federal, State, tribal, regional, and local EP staff - State Licensing and Certification Agency - Minnesota Office of Ombudsman - other sources of assistance On July 27, 2022, at 11:09 a.m., licensed assisted living director (LALD)-I acknowledged the EP plan was missing required elements. The licensee's Fire Safety Evacuation Plan and Fire Drills policy, dated July 20, 2021, indicated, "[licensee] will develop and maintain a compliant fire safety and evacuation plan." The policy noted, "this is the policy for the plans - the facility must develop the specific plans that would apply to their building." The licensee's Fire Policy, dated July 20, 2021,	0 680		

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0 680	Continued From page 16 indicated, "In the event of a fire, staff at [licensee] will assist in protecting and providing safety to the residents, staff and guests", and further noted, "this policy needs to be adapted to the type of fire alarm system installed in your building". No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to	0 730		

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0 730	Continued From page 17 the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record included documentation of all provided services for three of three residents (R1, R2, R3), and failed to document the disposition of medications for one of one resident (R4), 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).	0 730		

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0 730	Continued From page 18 The findings include: R1 R1 was admitted October 29, 2020, and began receiving services under the assisted living license on August 1, 2021. R1's service plan, dated October 29, 2020, indicated she received services which included assistance with housekeeping (weekly), socialization and activities (offered daily), safety checks (daily and every 2 hours at night), laundry (weekly on Mondays), meals (3 meals offered daily), vital signs (monthly and as needed (PRN)), dressing and grooming (twice daily, a.m. and p.m.), and bathing (weekly). R1's caregiver service documentation for July 1 through July 25, 2022, lacked documentation R1 received the following scheduled services: -housekeeping (weekly): 3 of 3 scheduled services; -socialization and activities (offered daily): 25 of 25 scheduled services; -safety checks (daily and every 2 hours at night): 125 of 125 scheduled services; -laundry (weekly on Mondays): 4 of 4 scheduled services; -meals (3 meals offered daily): 71 of 74 scheduled services; and -dressing and grooming (twice daily): 50 of 50 scheduled services. R2 R2 was admitted December 27, 2018, and began receiving services under the assisted living license on August 1, 2021. R2's service plan, dated December 27, 2019, indicated she received services which included	0 730		

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0 730	Continued From page 19 assistance with housekeeping (weekly), socialization and activities (offered daily), safety checks (daily and once per night), laundry (weekly on Fridays), meals (3 meals offered daily), vital signs (monthly and PRN), dressing and grooming (twice daily, a.m. and p.m.), toileting-assist with brief and perineal (peri) cares (nightly and as requested), and bathing (weekly). R2's caregiver service documentation for July 1 through July 25, 2022, lacked documentation R2 received the following scheduled services: -housekeeping (weekly): 3 of 3 scheduled services; -socialization and activities (offered daily): 25 of 25 scheduled services; -safety checks (daily and once per night): 49 of 49 scheduled services; -laundry (weekly on Fridays): 3 of 3 scheduled services; -meals (3 meals offered daily): 71 of 74 scheduled services; -dressing and grooming (twice daily): ; -toileting-assist with brief and peri cares (nightly): ; and -bathing (weekly): 3 of 3 scheduled services. R3 R3 was admitted April 17, 2020, and began receiving services under the assisted living license on August 1, 2021. R3's service plan, dated April 17, 2020, indicated she received services which included assistance with housekeeping (weekly), socialization and activities (offered daily), safety checks (daily and every 2 hours at night), laundry (weekly on Tuesdays), meals (3 meals offered daily), vital signs (monthly and PRN), and bathing (weekly).	0 730		

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0 730	Continued From page 20 R3's caregiver service documentation for July 1 through July 25, 2022, lacked documentation R3 received the following scheduled services: -housekeeping (weekly): 3 of 3 scheduled services; -socialization and activities (offered daily): 25 of 25 scheduled services; -safety checks (daily and every 2 hours at night): 125 of 125 scheduled services; -laundry (weekly on Tuesdays): 3 of 3 scheduled services; -meals (3 meals offered daily): 67 of 74 scheduled services; -vital signs (monthly): 1 of 1 scheduled service; and -bathing (weekly): 1 of 3 scheduled services. On July 27, 2022, during a 10:30 a.m. interview, registered nurse (RN)-D acknowledged the caregivers' service documentation was incomplete. RN-D agreed the licensee must have accurate documentation to show the agreed upon services are being provided. The licensee's Resident Record-Information and Content policy, dated July 19, 2021, indicated, "[licensee] will maintain appropriate and accurate records for each resident that is receiving assisted living services." The policy further indicated resident records must include, "documentation that services have been provided as identified in the service plan". No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		

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0 800	Continued From page 21	0 800		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment of the facility in a continuous state of good repair and operation. This has the potential to directly affect the health, safety, and well-being of all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On July 27, 2022, between the hours of 11:40 a.m. and 1:00 p.m., survey staff toured the facility with the licensed assisted living director (LALD)-I. During the tour survey staff observed and LALD-I verified the following: 1) The fire-rated door to the sprinkler riser/mechanical room failed to close tight and latch when released to maintain the fire protection	0 800		

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0 800	Continued From page 22 integrity between the room and the corridor. The latch and the door handle were broken and in need of repair. 2) The number keypad from the outside of the courtyard door on the assisted living side (dining room) was weathered, not legible, and failed to open when LALD-I attempted to use the keypad to enter back into the building. 3) The refrigerator door in the dementia care unit dining was partially opened and was not able to close tight to maintain the proper required food temperature. Upon further investigation, survey staff observed the upper compartment was a small freezer that was iced up and blocked the door from closing tight. Survey staff explained to LALD-I that because the door to the refrigerator was not able to close tight, the milk, yogurt, and food items were not able to maintain at 41 degrees Fahrenheit or less and must be discarded. LALD-I stated that the maintenance staff was available in the building and she would have them take care of it. 4) Resident rooms #3 and #5 on the assisted living side had oxygen cylinders inside but no warning oxygen signage on the doors. In addition, one of the oxygen cylinders in resident room #3 was not secured to prevent it from falling over which poses safety concerns to the resident. Survey staff explained to LALD-I that the storage, signage, and use of oxygen containers in resident rooms must be reviewed for compliance with the state fire code requirements. 5)The bathroom sliding door in the assisted living resident room #7 was missing a base piece to secure the door from swinging incorrectly posing potential safety concerns. On July 27, 2022, at approximately 2:15 p.m., LALD-I acknowledged the findings during the exit interview.	0 800		

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0 800	Continued From page 23 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system	0 810		

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0 810	Continued From page 24 activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide the minimum number of fire and evacuation drills. This has the potential to directly affect the safety of all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On July 27, 2022, at approximately 1:00 p.m., survey staff reviewed the licensee's fire safety and evacuation plan, drill, and training documentation. The documentation review indicated the following: 1) Employee fire drills did not meet the minimum required two fire and evacuation drills per shift per year, at minimum one every other month in accordance with Minnesota Statutes. The drill record provided for the review was dated June 21, 2022. The licensed assisted living director (LALD)-I stated that she was not able to find all the drill records. Survey staff agreed to honor additional drill records via email from LALD-I if provided by the end of the day for review. 2) Review of the employee fire drill records showed the licensee failed to indicate or provide	0 810		

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0 810	Continued From page 25 information to substantiate if the required evacuation drills were performed as part of the recorded fire drills. This was evident with comments on the fire drill records noting "did not evac". Fire drills and evacuation drills may be combined when conducting employee drills. On July 27, 2022, at approximately 2:15 p.m., LALD-I acknowledged the above findings during the exit interview. Additional information was provided by LALD-I via email on July 27, 2022, at 4:21 p.m. Survey staff received additional fire drill records dated, January 18, 2022, 9:00 a.m., March 24, 2022, at 10:00 p.m., and May 13, 2022, at 2:00 p.m. No drills records were provided for the previous year, 2021. TIME PERIOD FOR CORRECTION: Fourteen (14) days	0 810		
0 900 SS=C	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to	0 900		

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	33260	A. BUILDING: _____ B. WING _____	07/28/2022

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0 900	Continued From page 26 the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and execute a written assisted living contract with the required content for three of three residents (R1, R2, R3) with records reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not 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:	0 900		

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0 900	Continued From page 27 The licensee converted to an Assisted Living with Dementia Care license on August 1, 2021. R1 R1 was admitted October 29, 2020, and began receiving services under the assisted living license on August 1, 2021. R1's service plan, dated October 29, 2020, indicated R1 received services which included assistance with medication management, meals, housekeeping, laundry, diabetic management, and activities of daily living (ADLs). R2 R2 was admitted December 27, 2018, and began receiving services under the assisted living license on August 1, 2021. R2's service plan, dated December 27, 2019, indicated R2 received services including assistance with medication management, meals, housekeeping, laundry, diabetic management, and ADLs. R3 R3 was admitted April 17, 2020, and began receiving services under the assisted living license on August 1, 2021. R3's service plan, dated April 17, 2020, indicated R3 received services which included assistance with medication management, meals, housekeeping, laundry, and ADLs. R1, R2, and R3's records lacked a current assisted living contract with the required content, prior to providing assisted living services.	0 900		

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0 900	Continued From page 28 On July 26, 2022, at 4:05 p.m., licensed assisted living director (LALD)-I verified all residents admitted before August 1, 2021, used the previous contract, and all residents admitted after August 1, 2021, were provided the new Assisted Living contract. LALD-I stated all existing resident contracts had not been updated after the new licensure went into effect on August 1, 2021, because the contract language had not significantly changed. The licensee's Signing and Assisted Living Contract policy, dated August 1, 2021, indicated when a resident decided to move into the facility, an Assisted Living contract would be signed and received by the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 900		
0 950 SS=E	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 29 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, R3) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: The facility converted to an Assisted Living with Dementia Care license on August 1, 2021. R1 was admitted October 29, 2020, and began receiving assisted living services on August 1,	0 950		

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0 950	Continued From page 30 2021. R2 was admitted December 27, 2018, and began receiving assisted living services on August 1, 2021. R3 was admitted April 17, 2020, and began receiving assisted living services on August 1, 2021. R1, R2, and R3's records all lacked evidence they were given the opportunity to identify or to decline a designated representative. On July 26, 2022, at 11:13 a.m. licensed assisted living director (LALD)-I stated R1, R2, and R3 did not have signed forms indicating the right to designate a representative for certain purposes because they moved in prior to the requirement being added on August 1, 2021. LALD-I further stated the forms were provided to new admissions after August 1, 2021. The licensee's Designated Representative Policy, dated August 1, 2021, indicated, "before or at the time of execution of an assisted living contract, [licensee] will offer residents the opportunity to identify a designated representative in writing. A signed Designated Representative form must be filled out documenting the residents' choice in designated representative, the forms will be kept in the resident record." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950		

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0 970	Continued From page 31	0 970		
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 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 the twenty-eight (28) residents residing in the facility and future 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 the residents). The findings include: The licensee converted to an Assisted Living with Dementia Care license on August 1, 2021. The "[Licensee] Residency Agreement", section 8, indicated the provider was not liable to residents by including the following language:	0 970		

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0 970	Continued From page 32 -"Personal Property of Resident: No Liability of Management: Management has no responsibility to Resident or any third party for any personal property placed in the Residency unit or in any other location within the Facility or on its grounds by the owner of such personal property. Management is not responsible to Resident or any third party for loss of any personal property by theft or any other cause. Resident assumes all risk of harm or loss to any of Resident's personal property. Resident is encouraged to secure an apartment or renter's insurance policy to protect against such loss." -"Motor Vehicle Use: No Liability of Management: Resident is solely responsible for personal injury, property damage or other loss as a result of Resident's owning, maintaining, operating and/or parking a motor vehicle on or off the premises of the Facility. Management reserves the right to demand evidence of current registration and insurance on said vehicle, and of Resident's current and valid driver's license at any time. Failure to provide such evidence will be grounds for a restriction on vehicle use on the grounds of the Facility and/or termination of this Agreement." - "No Liability of Management for Certain Other Losses or Damages: Resident acknowledges familiarity with the Residency unit, the premises and services offered by Management and is therefore willing to, and does, assume all risks associated with occupancy. Resident further acknowledges that Management is not an insurer of Resident's safety. Management is not responsible for Resident's conduct or omissions of act or speech. Management, its employees, and its agents are not liable to Resident or to any other person for any loss or inconvenience of any kind, including personal injuries sustained by	0 970		

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0 970	Continued From page 33 Resident 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." -"Management is 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 Management's control and acting within the scope of their authority." On July 27, 2022, at 11:09 a.m., licensed assisted living director (LALD)-I confirmed the assisted living contract required residents to waive the facility's liability for health, safety, or personal property, and was included in all current residents' contracts. The licensee's Signing an Assisted Living Contract policy, revised August 1, 2021, indicated when a prospective resident decided to move into the facility, a contract was to be signed and received by the licensee. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 970		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days	01620		

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01620	Continued From page 34 from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to ensure the registered nurse (RN) completed a reassessment for a change in condition for one of five residents (R5) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R5 was admitted on October, 4, 2019, and began receiving Assisted Living with Dementia Care	01620		

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01620	Continued From page 35 services on August 1, 2021. R5's Service Plan Agreement dated July 13, 2022, indicated R5 received services including assistance with dressing and grooming, toileting, transfers, stand by assistance with front wheel walker for ambulation (walking), and safety checks every two hours. R5's record included a progress note dated July 21, 2022, that identified the following: -"Abrasion 2 cm to left elbow non-bleeding. Fell coming out of her doorway to her room did not have her walker with her." R5's Incident/Fall Investigation Report, dated July 20, 2022, included the following documentation by unlicensed personnel: "Resident walked out of room and lost balance and fail. Didn't have walker." The report indicated RN-J was notified of the fall July 21, 2022, but did not indicate a reassessment was completed. R5's record lacked documentation of a reassessment for falls risk or additional interventions subsequent to the July 20, 2022, fall. On July 26, 2022, at approximately 11:00 a.m., RN-A verified there were no follow up assessments completed regarding the fall dated July 20, 2022. On July 26, 2022, at 1:30 p.m., RN-A stated there should be a follow-up after each fall. RN-A indicated the follow-up would identify any new interventions needed that would be reflected in the service plan. On July 27, 2022, at 10:56 a.m., RN-D agreed a	01620		

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01620	Continued From page 36 follow up fall assessment should have been completed for R5 after the fall dated July 20, 2022. The licensee's Assessments, Reviews & Monitoring policy, dated July 20, 2021, indicated ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident. The licensee's Falls Prevention and Reduction policy, dated July 21, 2021, indicated, "If the RN believes the resident has a risk for falls, the RN will conduct a falls assessment, evaluate potential interventions to reduce or eliminate the risk, educate the resident and/or resident's representative and make recommendations for preventative actions the resident can take, such as physical therapy, exercise, etc. As part of the falls assessment, the RN will identify any hazards in the residents' suite and make recommendations to the resident and/or residents' representatives about the changes that can reduce hazards. The RN will incorporate any interventions to prevent or reduce the risk of falls into the resident's care plan and will communicate these interventions with staff providing services to the resident." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01620		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided,	01650		

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01650	Continued From page 37 the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan included the required content for three of three residents (R1, R2, R3), with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when	01650		

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01650	Continued From page 38 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). Findings include: R1, R3 R1 was admitted October 29, 2020, and began receiving assisted living services August 1, 2021. R3 was admitted April 17, 2020, and began receiving assisted living services August 1, 2021. R1 and R3's service plans, dated October 29, 2020 and April 17, 2020, respectively, lacked the schedule and methods of monitoring staff providing services. R2 R2 was admitted December 27, 2018, and began receiving assisted living services August 1, 2021. R2's record included a nursing assessment, dated June 9, 2022, that indicated R2 needed assistance with catheter care. R2's July 2022 Medication Administration Record (MAR), indicated R2 received assistance with catheter care daily from July 1 through July 27, 2022. R2's current service plan, dated December 27, 2019 lacked: -a description of the services to be provided according to the resident's current assessment, to include catheter care; and -the schedule and methods of monitoring staff providing services. On July 27, 2022, at 10:30 a.m., registered nurse	01650		

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01650	Continued From page 39 (RN)-D verified the catheter care services was not indicated on the service plan for R2, and schedule and method of monitoring staff providing services was not present on the service plans for R1, R2, and R3. RN-D confirmed all residents received the same service plan as it was generated through their electronic documentation system. The licensee's service plan policy, dated July 20, 2021, indicated, "All residents receiving assisted living services will have a service plan in place. Service plans are based on the outcomes of initial and subsequent assessments, reassessments, monitoring, and individual reviews of the resident's needs and preferences." The policy further indicated the service plan would include a description of the services that are to be provided based on the most recent assessment and resident preferences, and the schedule and method for monitoring of staff providing services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01650		
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's	01730		

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	33260	A. BUILDING: _____ B. WING _____	07/28/2022

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01730	Continued From page 40 assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) developed an individualized medication management plan with the required content for three of three residents	01730		

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01730	Continued From page 41 (R1, R2, R3), with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: R1 R1 was admitted October 29, 2020, and began receiving assisted living services August 1, 2021. R1's service plan dated October 29, 2020, indicated R1 received services including assistance with medication administration. The service plan further indicated medication administration was assigned to "HHA, RN, LPN." On July 26, 2022, at approximately 11:45 a.m., unlicensed personnel (ULP)-B was observed to administer medications to R1. R2 R2 was admitted December 27, 2018, and began receiving assisted living services August 1, 2021. R2's service plan, dated December 27, 2019 , indicated R2 received services including assistance with medication administration. The service plan further indicated medication administration was assigned to "HHA, RN, LPN." On July 26, 2022, at approximately 11:30 a.m., ULP-B was observed to administer medications	01730		

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01730	Continued From page 42 to R2. R3 R3 was admitted April 17, 2020, and began receiving assisted living services August 1, 2021. R3's service plan, dated April 17, 2020, indicated R3 received services including assistance with medication administration. The service plan indicated medication administration was assigned to "HHA, RN, LPN." R1, R2, and R3's individualized medication management plan lacked the following: -procedures for ULPs to notify a nurse if problems arose; and -documentation of specific resident instructions relating to the administration of medications. On July 26, at 12:45 p.m., ULP-C stated there are no specific instructions for when staff should report changes to a nurse. ULP-C further stated they (staff) don't have written documentation of specific resident instructions relating to the administration of medications. On July 27, 2022, at approximately 11:00 a.m., RN-D acknowledged staff did not have specific instructions for notifying the RN or licensed health professional when problems arose and documentation of specific resident instructions relating to the administration of medications. The licensee's Medication Management Individualized Plan policy, dated July 20, 2021, indicated, "[Licensee] will develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: a. A statement describing the medication	01730		

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01730	Continued From page 43 management services that will be provided b. A description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions c. Documentation of specific resident instructions relating to the administration of medications d. Identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis e. Identification of medication management tasks that may be delegated to unlicensed personnel f. Procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services, and g. Any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01760 SS=F	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	01760		

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01760	Continued From page 44 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 medications were administered per providers orders for three of three residents (R1, R2, R3) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: DOCUMENTATION R3 was admitted April 17, 2020, and began receiving assisted living services August 1, 2021. R3's service plan, dated April 17, 2020, indicated R3 received services including assistance with medication administration. R3's medication administration record (MAR) for July 2022, printed on July 27, 2022, at 9:52 a.m., lacked documentation the following scheduled medication doses had been administered: -Acidophilus capsule by mouth at bedtime for supplementation: 9:00 p.m. July 2, 12, 16, 19,	01760		

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01760	Continued From page 45 and 21, 2022; -pravastatin sodium (cholesterol lowering medication) one tablet 20 milligrams (mg) by mouth at bedtime: 9:00 p.m. July 2, 12, 16, 19, and 21 2022; -saphris (an antipsychotic) one tablet sublingual 10 mg at bedtime: 9:00 p.m. July 2, 12, 16, 19, and 21, 2022; -docu-soft (for constipation) capsule 100 mg two times per day by mouth: 8:00 p.m. July 2, 12, and 16, 2022; -lorazepam (anti-anxiety) tablet 0.5 mg "give 25 mg [sic]" (transposition error on dose which is addressed below) by mouth two times a day: 8:00 p.m. July 2, 12, and 16, 2022. TRANSCRIPTION R3's record included a physician order, signed February 21, 2022, that indicated, "Start Nasal Saline Spray, administer 1 spray into each nostril twice daily PRN" (as needed). The order was signed by registered nurse (RN)-J February 21, 2022. R3's MAR for July 2022, indicated, "Saline Nasal Spray Solution (Nasal Spray) 1 spray in both nostrils every 6 hours as needed for dry nasal -start date 2/21/2022 1245-", indicating an administration frequency of every 6 hours, instead of twice daily as indicated on the order. R3's record included a physician order, signed October 22, 2020, that indicated, "start Ativan [lorazepam] .25 mg PO [by mouth] BID [twice daily] for anxiety". The order was signed by RN-J October 23, 2020. R3's MAR for July 2022, indicated, "Lorazepam Tablet 0.5 MG Give 25 mg by mouth two times a day for anxiety	01760		

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01760	Continued From page 46 -Start Date- 10/23/2020 2000", indicating a dosage of 25 mg instead of 0.25 mg as indicated on the order. On July 26, 2022, at 1:30 p.m., RN-A stated refused medications should be documented with an"R" indicating the medication was refused. RN-A further stated the blanks likely indicate staff forgot to document, and that it would be expected that staff would document all medications administered. On July 26, 2022, at 2:48 p.m., RN-A acknowledged the transcription error related to R3's saline nasal spray. RN-A indicated the MAR would be updated. On August 3, 2022, at 12:32 p.m., upon being notified of an additional transcription error, related to R3's lorazepam order, licensed assisted living director (LALD)-I acknowledged the transcription error. LALD-I verified the medication had been dispensed correctly from the pharmacy, and administered correctly, and stated the error was corrected immediately. INSULIN ADMINISTRATION R2 R2 was admitted December 27, 2018, and began receiving assisted living services August 1, 2021. R2's service plan, dated December 27, 2019, indicated R2 received services including assistance with medication administration. On July 26, 2022, at approximately 11:30 a.m., unlicensed personnel (ULP)-B was observed to administer medications to R2. ULP-B failed to prime the insulin pen prior to administering 9 units(u) insulin to R2.	01760		

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01760	Continued From page 47 R1 R1 was admitted October 29, 2020, and began receiving assisted living services August 1, 2021. R1's service plan dated October 29, 2020, indicated R1 received services including assistance with medication administration. On July 26, 2022, at approximately 11:45 a.m., ULP-B was observed to administer medications to R1. ULP-B failed to prime the insulin pen prior to administering 1 u insulin to R1. On July 26, 2022, at 1:12 p.m., ULP-B confirmed she had not primed the insulin pen for R1 and R2 prior to injecting the insulin and was not aware she was supposed to. ULP-B indicated her understanding was to prime the insulin pen only prior to the first use, upon opening a new insulin pen. On July 26, 2022, at 1:30 p.m., RN-A stated staff are trained to prime insulin pens prior to every insulin administration. The licensee's Medication Management Administration and Setup policy, dated July 2021, indicated documentation of a medication reminder, medication assistance, or medication administration will be completed immediately after the task was performed, medication administration will be documented on the MAR by entering the ULP's initials under the date and opposite the medication and dose given and include the full signature and title of the person who provided the medication administration, ULP will record any problems with medication administration in the MAR including refusals, and ULP's will document any reason why medication	01760		

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01760	Continued From page 48 administration was not completed as prescribed. No further information provided TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01880 SS=E	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were stored according to manufacturer directions by storing medications in a refrigerator that were indicated to be stored at room temperature, and failing to maintain a temperature log to ensure appropriate storage of refrigerated medications. This had the potential to affect eight (8) residents with medications stored in the refrigerator. 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:	01880		

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01880	Continued From page 49 On July 26, 2022, at 1:50 p.m., the medication refrigerator in the nursing office was observed to lack a temperature log and thermometer. -at 1:51 p.m., Registered nurse (RN)-A verified no thermometer was present in the refrigerator, and daily log of refrigerator temperatures was not available. The following medications were observed stored in the refrigerator: R1: -1 pen Victoza (liraglutide-for diabetes); -1 pen Basaglar Kwik Pen (insulin glargine, a long-acting insulin); and -1 Novolog (insulin aspart, a fast-acting insulin) flexpen. R2: -1 pen Lantus Solostar (insulin glargine); and -4 pens Insulin Lispro (a fast-acting insulin) Injection Kwikpen. R7: -1 bottle Latanoprost ophthalmic (for glaucoma); and -3 pens Lantus solostar (insulin glargine). R8: - 4 bottles Rhopressa (netarsudil-for glaucoma). R9: -2 pens Basaglar (insulin glargine). R10: -3 pens Humalog (insulin lispro, a fast-acting insulin) Kwikpen; and -1 pen Lantus solostar (insulin glargine). R11:	01880		

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01880	Continued From page 50 -7 pens Novolog (insulin aspart); and -3 pens Tresiba Flex Touch (insulin degludec, an ultra long-acting insulin). R12: -Lotemax SM Gel (Loteprednol etabonate, an ophthalmic anti-inflammatory); -Prolensa Ophthalmic (bromfenac, an anti-inflammatory); and -Moxifloxacin ophthalmic solution (an anti-infective). Manufacturer storage directions observed in the packaging for Victoza indicated to refrigerate the medication. Manufacturer storage directions observed in the packaging for Basaglar Kwik Pen insulin glargine indicated to store unused pens in the refrigerator at 36-46 degrees Fahrenheit (F). Manufacturer storage directions observed in the packaging for Novolog flexpen insulin aspart indicated to store refrigerated at 2 degrees Celsius (C) to 8 degrees C (36 degrees F to 46 degrees F) until first use. Manufacturer storage directions observed in the packaging for Lantus Solostar insulin glargine indicated "unopened LANTUS solostar devices should be stored in a refrigerator, 36 - 46 degrees". Manufacturer storage directions observed in the packaging for Insulin Lispro Injection Kwikpen indicated, "can be kept unrefrigerated below 86 degrees 28 days or refrigerated until expiration date". Manufacturer storage directions observed in the	01880		

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01880	Continued From page 51 packaging for Latanoprost ophthalmic indicated, "store unopened bottles under refrigeration 36-46 degrees". Manufacturer storage directions observed in the packaging for Rhopressa indicated, "store at 36-46 degrees until opened". Manufacturer storage directions observed in the packaging for Humalog Kwikpen indicated, "store unused pens in the refrigerator at 36-46 degrees F. Manufacturer storage directions observed in the packaging for Tresiba Flex Touch indicated, "Keep in a cold place until first use. Store at 36-46 degrees." Manufacturer storage directions observed in the packaging for Lotemax SM gel indicated, "Store upright at 59-77 degrees." Manufacturer storage directions observed in the packaging for Prolensa Ophthalmic indicated, "Store at 59-77 degrees." Manufacturer storage directions observed in the packaging for Moxifloxacin ophthalmic solution indicated, "Store at 59-77 degrees." On July 26, 2022, at 2:19 p.m., RN-A acknowledged the eye medications for R12 were indicated to be stored at room temperature. RN-A indicated she was not aware of the storage recommendations for the eye medications and would ensure the medications were stored appropriately. RN-A verified the remainder of the medications should be stored refrigerated according to manufacturer directions.	01880		

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01880	Continued From page 52 The licensee's medication storage policy, dated July 20, 2021, indicated, "Medications will be stored consistent with manufacturer's recommendations (refrigerated, room temperature, or frozen)." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
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 licensee failed to provide documentation in the	01910		

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resident's record regarding the disposition of medication to include quantity and names of staff and other individuals involved in the disposition of medications for one of one discharged resident (R4) with record reviewed.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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:

R4 was admitted February 22, 2022, and discharged June 8, 2022. R4 received services including assistance with medication administration.

R4's medication administration record (MAR) for June 2022, indicated R4 was last administered medications by the licensee on June 8, 2022, before transferring to a sister facility. The MAR indicated R4 was prescribed the following scheduled medications: aspirin 81 milligrams(mg), atorvastatin calcium (a cholesterol lowering medication) 20 mg, fluoxitine hydrochloride (an antidepressant) 40 mg, furosemide (a diuretic) 20 mg, Lisinopril (a blood pressure medication) 5 mg, melatonin (a sleep aid) 6 mg, metoprolol succinate (a blood pressure medication) 12.5 mg, polyethylene glycol (for constipation) 17 grams (gm), omeprazole (for acid reflux) 20 mg, tamsulosin (for urinary health) 0.4 mg, buspirone (anti anxiety) 7.5 mg, oxycodone hydrochloride (for pain) 5 mg, senna (a laxative) 1 tablet, ticagrelor (an anticoagulant)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33260	A. BUILDING: _____ B. WING _____	07/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUITE LIVING SENIOR CARE OF VA	580 LIBERTY WAY VADNAIS HEIGHTS, MN 55127

(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 54 90 mg, acetaminophen (for pain) 500 mg, and gabapentin (for pain) 500 mg. In addition to the scheduled medications, the MAR indicated R4 received the following as needed (PRN) medications: acetaminophen 325 mg, calcium antacid 500 mg, bisacodyl laxative suppository 10 mg, loratidine (for allergies) 10 mg, guaifenesin 200 mg/10 milliliters (ml) (for cough), hydrocortisone cream 1%, azothioprine (for arthritis) 50 mg, lip balm, loperamide (for loose stools) 2 mg, menthol cough drops, milk of magnesia 30 ml, nitroglycerin (for chest pain) 0.4 mg, Nystatin powder, oxycodone hydrochloride 5 mg, tizanidine (for muscle spasm) 2 mg, and triple antibiotic ointment. R4's medical record included a discharge summary dated June 8, 2022. The discharge summary lacked information related to the transfer or disposition of R4's medications. On July 25, 2022, at 3:08 p.m., registered nurse (RN)-A stated she could not locate a disposition or destruction of medications form for R4. RN-A stated the nurse at R4's admitting facility indicated medications were ordered for R4 upon admission. RN-A stated possibly R4 was at the end of his medication "cycle" and therefore did not have any medications to destroy or transfer. On July 27, 2022, at approximately 10:48 a.m., RN-D verified R4's discharge summary did not include a record of the disposition of medications for R4 to include the prescription number and quantity of medications released or disposed. RN-D indicated they were aware of the requirement, under the assisted living licensure, to document disposition of medications even if the resident is discharged to a sister facility.	01910		

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01910	Continued From page 55 No further information provided. Time period for correction: Twenty-one (21) days	01910		
01940 SS=F	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes.	01940		

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01940	Continued From page 56 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) developed a treatment management plan to include all required content for two of two residents (R1, R2) with treatment services records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: R1 R1 was admitted October 29, 2020, and began receiving assisted living services August 1, 2021. On July 26, 2022, at approximately 11:45 a.m., unlicensed personnel (ULP)-B was observed to assist R1 with blood glucose monitoring. R1's service plan, dated October 29, 2020, indicated R1 received treatment services including assistance with blood glucose monitoring and biPap (a device to prevent sleep apnea). The service plan further indicated blood glucose monitoring was assigned to "HHA (unlicensed personnel), RN, LPN (licensed practical nurse)." and biPap was assigned to "HHA" R1's treatment and therapy management plan	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01940	Continued From page 57 lacked instruction to unlicensed staff including procedures for notifying a nurse or appropriate licensed health professional if a problem arose with the treatments or therapy services. R2 R2 was admitted December 27, 2018, and began receiving assisted living services August 1, 2021. On July 26, 2022, at approximately 11:15 a.m., ULP- B was interviewed and indicated R2 was supposed to wear compression stockings, but often refused. On July 26, 2022, at approximately 11:30 a.m., ULP-B was observed to assist R2 with blood glucose monitoring. R2's nursing assessment, dated June 9, 2022, indicated R2 used compression stockings and received assistance with "blood sugar checks". R2's July 2022 Medication Administration Record (MAR), indicated R2 received assistance with compression stockings daily from July 1 through July 27, 2022. R2's service plan, dated December 27, 2019, indicated R2 recieved treatment services including assistance with blood glucose monitoring, but lacked information related to assistance with compression stockings. The service plan further indicated blood glucose monitoring was assigned to "HHA, RN, LPN." R2's treatment and therapy management plan lacked instruction to unlicensed staff including procedures for notifying a nurse or appropriate licensed health professional if a problem arose with the treatments or therapy services.	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33260	A. BUILDING: _____ B. WING _____	07/28/2022

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01940	Continued From page 58 On July 27, 2022, at 10:30 a.m., RN-D acknowledged R2's service plan lacked information related to compression stocking treatment. RN-D further acknowledged treatment management plans were required to include the procedure for unlicensed staff to notify the nurse with any problems. The licensee's Treatment & Therapy Management Plan policy, dated July 2021, indicated, "For each resident at [licensee] receiving management of ordered or prescribed treatments or therapy services, the facility will prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident." The policy further indicated, "[Licensee] will develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: a. A statement of the type of services that will be provided b. Documentation of specific resident instructions relating to the treatments or therapy administration c. Identification of treatment or therapy tasks that will be delegated to unlicensed personnel d. Procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services e. Any resident-specific requirements relating to documentation of treatment and therapy received f. Verification that all treatment and therapy was administered as prescribed g. Monitoring of treatment or therapy to prevent possible complications or adverse reactions." No further information was provided.	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01940	Continued From page 59 TIME PERIOD FOR CORRECTION: Seven (7) days.	01940		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on observation, document review, and interview, the licensee failed to provide a complete hazard vulnerability or safety risk assessment plan to identify hazard vulnerabilities and mitigations on and around the property to protect the residents from potential harm. This has the potential to directly affect all memory care residents receiving assisted living services. 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 residents).	02040		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02040	Continued From page 60 The findings include: On July 27, 2022, at approximately 1:00 p.m., survey staff reviewed the facility's hazard vulnerability assessment plan (undated) documentation. The documentation review indicated the following findings: 1)The plan documentation was incomplete and lacked local/site-specific hazard content on the assessment on and around the property to protect the memory care residents from harm. More specifically, the plan lacked hazard assessments from the risks of elopement from the unsecured windows in the sunroom, compromised windows in resident rooms #19, #20, and #27, the courtyard with unsecured gates, deactivation of power doors due to loss of power or fire alarm activation, and potential risk around the property such as busy roads. In addition, a hazard assessment must also include the risk of residents accessing the toaster in the dining area exposing them to heated elements and/or sharp tools or objects. 2)The plan documentation lacked mitigation to each assessed risk to ensure effectively respond to all potential hazards that could directly affect all memory care residents. Specific prevention measures to mitigate risks from the identified potential hazard and vulnerability assessment must be developed and documented in the plan for all potential harm. On July 27, 2022, at approximately 2:15 p.m. during the exit interview, survey staff discussed the findings and explained to licensed assisted living director (LALD)-I that their plan must be expanded to include all potential safety risks or	02040		

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02040	Continued From page 61 harm and mitigations must be addressed on and around the property. The LALD-I acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	02040		
02110 SS=E	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and 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	02110		

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02110	Continued From page 62 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 policies and procedures for assisted living with dementia care were provided to residents and the residents' legal and designated representatives for three of three residents (R1, R2, R3) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: The licensee converted to an Assisted Living with Dementia Care license on August 1, 2021. R1 R1 was admitted October 29, 2020, and began receiving services under the assisted living license on August 1, 2021. R1's service plan, dated October 29, 2020, indicated R1 received services which included	02110		

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02110	Continued From page 63 assistance with medication management, meals, housekeeping, laundry, diabetic management, and activities of daily living (ADLs). R2 R2 was admitted December 27, 2018, and began receiving services under the assisted living license on August 1, 2021. R2's service plan, dated December 27, 2019, indicated R2 received services including assistance with medication management, meals, housekeeping, laundry, diabetic management, and ADLs. R3 R3 was admitted April 17, 2020, and began receiving services under the assisted living license on August 1, 2021. R3's service plan, dated April 17, 2020, indicated R3 received services which included assistance with medication management, meals, housekeeping, laundry, and ADLs. R1, R2, and R3's records lacked documentation policies and procedures for assisted living with dementia care were provided. On July 27, 2022, at 11:09 a.m., licensed assisted living director (LALD)-I acknowledged dementia care policies and procedures were required to be provided to residents admitted prior to August 1, 2021. LALD-I stated the policies and procedures were included in the new admit documentation. LALD-I indicated their understanding was that it was not required since the statute language stated it should be presented at the time of move in, and the residents were already admitted.	02110		

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02110	Continued From page 64 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02110		

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

Type: Full
Date: *07/25/22*
Time: 11:43:50
Report: 1004221159

Food and Beverage Establishment Inspection Report

Location:
Suite Living Senior Care Of Va
580 Liberty Way
Vadnais Heights, MN55127
Ramsey County, 62

Establishment Info:
ID #: 0039320
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6514240045
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.

3-300C Protection from Contamination: equipment/utensils, consumers

3-304.14B

MN Rule 4626.0285B Wiping cloths used for wiping counters and other equipment surfaces must be held in an approved sanitizing solution and laundered daily.

QUATERNARY AMMONIUM CONCENTRATION IN THE WET WIPING CLOTH BUCKET MEASURED AT 0PPM. ENSURE A CONCENTRATION OF 200-400PPM IS MAINTAINED TO PREVENT BACTERIAL GROWTH.

Comply By: 07/25/22

4-200 Equipment Design and Construction

4-204.112A

MN Rule 4626.0620A Provide a temperature measuring device located in the warmest part of mechanically refrigerated units and coolest part of hot food storage units that are capable of measuring air temperature or a simulated product temperature.

NO INTERNAL TEMPERATURE MEASURING DEVICES LOCATED IN THE 2 NORLAKE COOLERS. PROVIDE AND MAINTAIN IN THE WARMEST PART OF THE UNIT (CLOSE TO THE DOOR).

Comply By: 07/25/22

Surface and Equipment Sanitizers

Wash Temp. Gauge: = at 155 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Rinse Temp. Gauge: = at 180 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Utensil Surface Temp.: = at 164 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Quaternary Ammonia: = 200PPM at Degrees Fahrenheit
Location: SANITIZER SPRAY BOTTLE
Violation Issued: No

Quaternary Ammonia: = 0PPM at Degrees Fahrenheit
Location: WET WIPING CLOTH BUCKET
Violation Issued: Yes

Quaternary Ammonia: = 400PPM at Degrees Fahrenheit
Location: SANITIZER DISPENSER (3-COMP)
Violation Issued: No

Food and Equipment Temperatures

Process/Item: POTATO SALAD
Temperature: 38 Degrees Fahrenheit - Location: NORLAKE COOLER #1
Violation Issued: No

Process/Item: SAUSAGE
Temperature: 36 Degrees Fahrenheit - Location: NORLAKE COOLER #2
Violation Issued: No

Process/Item: MILK
Temperature: 37 Degrees Fahrenheit - Location: NORLAKE COOLER #2
Violation Issued: No

Process/Item: BURGER PATTY
Temperature: 184 Degrees Fahrenheit - Location: STEAM TABLE
Violation Issued: No

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

INSPECTION WAS CONDUCTED BY MOLLY DOUGHERTY (FPLS) IN CONJUNCTION WITH A HEALTH REGULATIONS DIVISION (HRD) SURVEY CONDUCTED BY RENEE ANDERSON.

DISCUSSED:
-EMPLOYEE ILLNESS POLICY AND LOG
-HANDWASHING
-SANITIZER USE AND TEST KITS
-VERIFYING DISH MACHINE UTENSIL SURFACE SANITIZING TEMPERATURES
-CLEANING/SANITIZING FOOD CONTACT SURFACES AND UTENSILS
-DATE MARKING PROCEDURES
-REHEATING PROCEDURES
-COOLING PROCEDURES
-THERMOMETER USE AND CALIBRATION
-SERVING A HIGHLY SUSCEPTIBLE POPULATION (NO RAW/UNDERCOOKED ANIMAL FOODS, NO UNPASTEURIZED JUICE, MILK, ETC)
-VOMIT/FECAL INCIDENT CLEAN UP PROCEDURES
-PEST CONTROL

-FOOD SOURCE AND RECEIVING DELIVERIES PROCEDURES

*REPORT WAS DISCUSSED WITH FOOD SERVICE OPERATOR, PHIL, AND THE NURSE EVALUATOR, RENEE AT THE CONCLUSION OF THE INSPECTION.

*IF ANY RESIDENT COMPLAINS OF ILLNESS, CONTACT THE MINNESOTA DEPARTMENT OF HEALTH AND PROVIDE THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER TO THE RESIDENT, OR CALL ON THEIR BEHALF. THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER IS 1-877-366-3455.

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 1004221159 of 07/25/22.

Certified Food Protection Manager: PHILLIP MICHAEL SPARISH

Certification Number: FM47754 Expires: 05/09/25

Signed: _____

PHIL SPARISH
FOOD SERVICE OPERATOR

Signed: Molly Dougherty

Molly Dougherty
Public Health Sanitarian
Metro District Office
651-201-3978
molly.dougherty@state.mn.us