DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

June 13, 2023

Licensee
The Homestead at Anoka
3002 4th Avenue North
Anoka, MN 55303

RE: Project Number(s) SL29856015

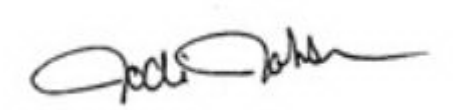
Dear Licensee:

On June 7, 2023, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the February 1, 2023, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,



Jodi Johnson, Supervisor
State Evaluation Team
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 651-281-9796

HHH

Electronically Delivered

March 14, 2023

Licensee
The Homestead At Anoka
3002 4th Avenue North
Anoka, MN 55303

RE: Project Number(s) SL29856015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on February 1, 2023, 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.

LICENSING ORDERS
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 - 2070 - 144g.81 Subd. 4 - Awake Staff Requirement - $3,000.00

The total amount you are assessed is $3,000.00. You will be invoiced approximately 30 days after 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 reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for 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

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. Requests for hearing may be emailed to: **Health.HRD.Appeals@state.mn.us**.

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

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

Sincerely,

Jess Schoenecker, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: Jess.Schoenecker@state.mn.us
Phone: 651-201-3789 Fax: 651-215-9697

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29856	A. BUILDING: _____ B. WING _____	02/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HOMESTEAD AT ANOKA	3002 4TH AVENUE NORTH ANOKA, MN 55303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL29856015 On January 30, 2023, through February 1, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 75 residents all whom received services under the Assisted Living with Dementia Care license. On January 31, 2023, the immediacy of correction order 2070 has been removed, however non-compliance remains at a scope and level of I.	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 (a) All assisted living facilities must provide to	0 430		

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0 430	Continued From page 1 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 observation, interview, and record review, the licensee failed to provide a copy of the uniform checklist disclosure of services and amenities (UDALSA) with the required content for four of five residents (R2, R3, R4, R5). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R2	0 430		

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0 430	Continued From page 2 R2 admitted to licensee November 1, 2019, under the comprehensive license and started receiving assisted living services August 1, 2021. R2's Service and Payment Agreement signed October 16, 2019, indicated R2 received as needed assistance with long term care insurance assistance, skilled nursing, home health aide for activities of daily living and mobility, medication set up, medication administration, shower assistance, escort service, and housekeeping. R2's record included Statement of Home Care Services Comprehensive Home Care Provider signed October 16, 2019. On January 31, 2023, at 9:36 a.m., while unlicensed personnel (ULP)-E completed a medication pass for R2, the evaluator observed a person, who identified themselves as marketing, stated to R2, "I need you to sign a UDALSA so we can have it for our record." On January 31, 2022, at 1:49 p.m., registered nurse (RN)-B provided the evaluator a document titled Uniform Disclosure of Assisted Living Services & Amenities signed January 21, 2023. RN-B verified the document listed above was provided to R2 on January 21, 2023. R3 R3 admitted to licensee April 20, 2019, under the comprehensive license and started receiving assisted living services August 1, 2021. R3's signed service plan dated July 28, 2021, indicated R3 received assistance with Nursing services, laundry assistance, toileting, dressing, showering, personal hygiene and grooming, ambulation, transfers, medication set up, and	0 430		

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0 430	Continued From page 3 medication administration. R4 R4 was admitted to licensee January 10, 2023, for assisted living services. R4's unsigned service plan printed January 1, 2023, indicated R4 received assistance with laundry assistance, toileting, dressing, bathing, personal hygiene and grooming, transfers, and medication administration. R5 R5 was admitted to licensee March 11, 2021, under the comprehensive license and started receiving assisted living services August 1, 2021. R5's unsigned service plan printed January 1, 2023, indicated R5 received assistance with transportation, laundry assistance, toileting, dressing, bathing/showering, personal hygiene and grooming, mobility including ambulation and transfers, eating assistance, housekeeping, and medication administration. R2, R3, R4, and R5's records lacked a UDALSA checklist to include: - a disclosure of the categories of assisted living licenses available and the category of license held by the facility; and - 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. On February 1, 2023, at 12:50 p.m., licensed assisted living director (LALD)-C stated the intake department handles all intake paperwork	0 430		

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0 430	Continued From page 4 including UDALSA, and the resident signs off a checklist which licensee was not able to find. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 430		
0 450 SS=C	144G.41 Subdivision 1 Minimum requirements All assisted living facilities shall: (1) distribute to residents the assisted living bill of rights; (2) provide services in a manner that complies with the Nurse Practice Act in sections 148.171 to 148.285; (3) utilize a person-centered planning and service delivery process; (4) have and maintain a system for delegation of health care activities to unlicensed personnel by a registered nurse, including supervision and evaluation of the delegated activities as required by the Nurse Practice Act in sections 148.171 to 148.285; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide the current Minnesota Assisted Living Bill of Rights (BOR) to five of five residents (R1, R2, R3, R4, R5). 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 the	0 450		

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0 450	Continued From page 5 residents). The findings include: R1 R1 admitted to licensee February 14, 2019, under the comprehensive license and started receiving assisted living services August 1, 2021. R1's record included a document titled Current Resident Admission Acknowledgment Form signed November 9, 2022, which indicated R1's record lacked the acknowledgment for receiving the current assisted living BOR. R2 R2 admitted to licensee November 1, 2019, under the comprehensive license and started receiving assisted living services August 1, 2021. R2's record included a document titled Current Admission Acknowledgement form signed February 1, 2020, which indicated R2's record lacked the acknowledgment for receiving the current assisted living BOR. R3 R3 admitted to licensee April 20, 2019, under the comprehensive license and started receiving assisted living services August 1, 2021. R3's record included a Homecare BOR with a Current Resident Admissions Acknowledgment Form signed and dated July 28, 2021, which indicated R3's record lacked receiving the current assisted living BOR. R4 R4 admitted to licensee January 10, 2023, for assisted living services.	0 450		

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0 450	Continued From page 6 R5 R5 admitted to licensee March 11, 2021, under the comprehensive license and started receiving assisted living services August 1, 2021. R5's record included a Homecare BOR with an acknowledgement signed and dated January 28, 2020. R1, R2, R3, R4, and R5's record lacked a written acknowledgement for receiving a current assisted living BOR. On February 1, 2022, registered nurse (RN)-A stated residents would receive the BOR during the admission process. RN-A stated they were unaware of why R1, R2, R3, R4, R5's records lacked the BOR because a different department was responsible to provide the residents with the document. The licensee's Minnesota Bill of Rights for Assisted Living Residents document dated effective August 1, 2022, indicated before the initiation of services residents have the right to be informed by the facility of the rights granted under the MN Statute 144G.91 and the recourse residents have if rights are violated. The document also indicated a written acknowledgement of the receipt of the Bill of Rights will be retained in the resident record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 450		

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0 480	Continued From page 7	0 480		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated January 30, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that	0 510		

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0 510	Continued From page 8 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 observations, interview, and record review, the facility failed to establish and maintain an effective infection control program that complied with accepted health care, medical and nursing standards for infection control related to gloving and hand hygiene for one of six residents (R8). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On January 31, 2023, from 7:47 a.m., to 8:08 a.m., the evaluator observed unlicensed personnel (ULP)-I enter R8's apartment and don clean gloves without first preforming hand hygiene. ULP-I assisted R8 from the bed to the toilet and assisted with toileting, including	0 510		

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0 510	Continued From page 9	0 510		

removing the incontinence brief. The brief was observed to be soiled with urine and was placed into the bathroom trash receptacle. Without removing the soiled gloves and performing hand hygiene, ULP-I washed R8's body, provided peri care, and applied barrier cream. ULP-I removed the soiled gloves and donned clean gloves without preforming hand hygiene, then assisted R8 with dressing. ULP-I again removed the soiled gloves and donned clean gloves without preforming hand hygiene, then assisted R8 with hair brushing and oral cares.

On January 31, 2023, at 8:40 a.m., ULP-I stated the staff were trained to "wash hands before and after cares, after you change gloves and to wash hands whenever visibly soiled."

On February 1, 2023, at 1:05 p.m., registered nurse (RN)-A provided a document titled Lippincott Procedures - Hand Hygiene dated August 19, 2022, and stated "that is what we [the licensee] use for our hand washing policy."

On February 1, 2023, at 1:51 p.m., RN-A stated staff were trained to preform hand hygiene "when you enter and exit a resident's room, before you put on or take off gloves, gloving should be done if exposed to bodily fluids, and changed anytime in between services provided, or if they become dirty."

The Centers for Disease Control and Prevention (CDC) Hand Hygiene in Health Care Settings Healthcare Providers guidance dated January 30, 2020, directed health care workers to wash their hands immediately before touching a patient [resident], after touching a patient or patient's immediate environment, after glove removal, and when hands were visibly soiled.

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0 510	Continued From page 10 The licensee's document titled Lippincott Procedures - Hand Hygiene dated August 19, 2022, read, "using an alcohol-based hand rub is appropriate for decontaminating the hands before direct contact; before putting on gloves; before inserting an invasive device; after contact with a patient; when moving from a contaminated body site to a clean body site during patient care; after contact with body fluids, excretions, mucous membranes, nonintact skin, or wound dressings (if hands aren't visibly soiled); after removing gloves; and after contact with inanimate objects in the patient's [resident's] environment. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 650 SS=F	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement	0 650		

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THE HOMESTEAD AT ANOKA	3002 4TH AVENUE NORTH ANOKA, MN 55303

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0 650	Continued From page 11 needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency documentation was maintained for two of two employees (unlicensed personnel (ULP)-C, registered nurse (RN)-B) to include all required content. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: RN-B RN-B was hired as an independent contractor on November 1, 2021, as the director of nursing. RN-B's record lacked documentation of orientation requirements for the following topics: - policy and procedure acknowledgements; - reporting maltreatment of vulnerable adults or minor; - handling of resident complaints, reporting complaints, where to report; - consumer advocacy services;	0 650		

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0 650	Continued From page 12 - principles of person-centered planning/service delivery; and - orientation to each specific resident and services provided. On February 1, 2023, at 1:30 p.m., licensed assisted living director (LALD)-C stated RN-B had not signed the acknowledgment page of the policies and procedures, but the review had been done. LALD-C stated that he was new and did not know where or how to track the independent contractor's orientation completion. ULP-C ULP-C was hired on November 1, 2021. ULP-C's record lacked documentation of completed annual training for the following topics: - reporting maltreatment of vulnerable adults or minors; - assisted Living bill of rights; - infection control techniques; - review of provider's policies and procedures; - principles of person-centered planning/service delivery; and - dementia Training: two hours annually. On February 1, 2023, at 1:55 p.m., RN-A indicated ULP-C's record lacked documentation of the required annual training. RN-A stated the training was completed in all required topics but could not locate them in the licensee's system. RN-A stated they would be putting a better tracking system into place. The licensee provided the evaluator an undated document titled Personnel File Checklist for employee records the licensee would maintain however, the document did not address the requirements of current licensure.	0 650		

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0 650	Continued From page 13 No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included baseline testing and screening for two of two employees (unlicensed personnel (ULP)-E, registered nurse (RN)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 660		

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0 660	Continued From page 14 safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's TB facility risk assessment tool dated April 2022, indicated the licensee had a low risk for TB. ULP-E ULP-E was hired on November 1, 2022. ULP-E's record included the employee screening tool for TB dated October 25, 2022, which indicated ULP-E had a previous reaction to TB skin test, however, did not include the documentation of the previous positive reaction. ULP-E's record lacked a new positive skin test or refusal of skin test on hire. ULP-E's record included letter from clinic dated August 1, 2019, and negative results of chest x-ray. ULP-E's record lacked a TB skin test or new x-ray at time of hire. RN-B RN-B was hired on November 1, 2022, as an independent contractor for the temporary director of nursing. RN-B's record included a TB screening tool and result dated December 4, 2021. RN-B's record lacked a TB symptom screening tool and TB skin test at time of hire.	0 660		

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0 660	Continued From page 15 On February 1, 2023, at 2:55 p.m., infection control preventionist (ICP)-J stated new employees complete a TB screening tool on hire and would be required to complete a new skin test with a positive result before requesting a chest x-ray. ICP-J further stated if a positive skin test or refusal of the skin test occurred licensee would require a new chest x-ray with a negative result before employee could work with residents. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 700 SS=F	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure residents' personal health and medical information was kept private. This had the potential to affect five of five residents (R7, R9, R10, R13, R14). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a	0 700		

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0 700	Continued From page 16	0 700		

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 January 31, 2023, at 8:00 a.m., the evaluator observed unlicensed personnel (ULP)-F leave a computer open on a cart unattended in the common hallway outside of the resident's room for ten minutes. ULP-F left R7's medication administration record open on the screen and the computer unattended. There were two wandering residents in the common hallway.

On January 31, 2023, at 8:15 a.m., the evaluator observed ULP-F leave a computer open on a cart unattended in the common hallway outside of the residents' room for five minutes. ULP-F left R9's medication administration record open on the screen and the computer unattended. There was one housekeeper in the hallway.

On January 31, 2023, at 8:27 a.m., the evaluator observed ULP-F leave a computer open on a cart unattended in the common hallway outside of the resident's room for five minutes. ULP-F left R14's medication administration record open on the screen and the computer unattended.

On January 31, 2023, at 8:35 a.m., the evaluator observed ULP-F leave a computer open on a cart unattended in the common hallway outside of the resident's room for ten minutes. ULP-F left R13's medication administration record open on the screen and the computer unattended. There were two wandering residents in the hallway.

On February 1, 2023, at 9:00 a.m., registered

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0 700	Continued From page 17 nurse (RN)-A stated staff are expected to shut down their computer screens anytime that they walk away from their computer to keep private information protected. RN-A further stated the licensee trains how to keep private health information stored and nothing should be left where others can see private information. The licensee's Resident Records - Confidentiality, Access and Transfer policy dated August 1, 2021, indicated all staff members are responsible to protect residents, whether written or electronic against loss, tampering, or unauthorized disclosure. Residents have the right to have personal, financial, health and medical information kept private, to approve and refuse release of information to any outside party. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 700		
0 780 SS=D	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but	0 780		

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0 780	Continued From page 18 not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide interconnected smoke alarms for resident apartment unit 108. This has the potential to directly affect the resident in resident unit 108. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On January 31, 2023, approximately from 11:30 a.m. to 12:15 p.m., survey staff toured the facility with the licensed assisted living director (LALD)-C. At approximately 12:15 p.m., the tour was replaced with the skilled administrator (SA)-K until 2:10 p.m. At approximately 1:35 p.m. during the tour, survey	0 780		

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0 780	Continued From page 19 staff observed smoke alarm inside the sleeping room of apartment unit 108 did not sound when the SA-K tested the smoke alarm located in the hallway of the sleeping room. On January 31, 2023, at approximately 3:30 p.m., during the exit interview, the LALD-C acknowledged the above finding. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 780		
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	0 810		

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0 810	Continued From page 20 proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to provide the complete content and accurate fire safety and evacuation plan and the minimum required training of residents capable of assisting evacuation during a fire or similar emergency. This has the potential to directly affect the safety of all residents receiving services, 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 January 31, 2023, approximately from 11:30 a.m. to 12:15 p.m., survey staff toured the facility with the licensed assisted living director (LALD)-C. At approximately 12:15 p.m., the tour was replaced with the skilled administrator-K until	0 810		

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0 810	Continued From page 21 2:10 p.m. On January 31, 2023, at approximately 11:00 a.m. and 2:30 p.m., survey staff received the facility fire safety and evacuation plan and related documentation for review from the licensed assisted living director (LALD)-C. At approximately 3:15 p.m., document review and interview with the LALD-C indicated the following findings: 1. The current fire safety and evacuation procedures direct employees to pull a fire pull station located in stairway B, but when asked, the LALD-C failed to locate the pull station in stairway B or a pull station in the assisted living facility. During the interview, the LALD-C verified that the plan lacked accuracy and needed to be revised. 2. The evacuation first-floor plan layout was not accurate. The set of double fire doors on the first floor located near the chapel was shown on the incorrect side of the set of double fire doors. 3. The licensee lacked a record to show that required annual resident training was available that can self-assist in their own evacuation on proper actions to take in the event of a fire including movement, evacuation, or relocation. No record was available or provided for review. On January 31, 2023, at approximately 3:30 p.m., during the exit interview, the LALD-C acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		

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0 970	Continued From page 22	0 970		
0 970 SS=C	144.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal property of a resident for five of five residents (R1, R2, R3, R4, R5). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 admitted to licensee February 14, 2019, under the comprehensive license and started receiving assisted living services August 1, 2021. R2 admitted to licensee November 1, 2019, under the comprehensive license and started receiving assisted living services August 1, 2021.	0 970		

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0 970	Continued From page 23 R3 admitted to licensee April 20, 2019, under the comprehensive license and started receiving assisted living services August 1, 2021. R4 admitted to licensee January 10, 2023, for assisted living services. R5 admitted to licensee March 11, 2021, under the comprehensive license and started receiving assisted living services August 1, 2021. R1, R2, R3, R4, and R5's Assisted Living Contract signed November 9, 2022, July 21, 2021, July 28, 2021, January 5, 2023, and July 20, 2021, respectively, included the following two sections: - Indemnification which read, "Residents will indemnify and hold harmless provider, its employees and agents from and against any and all claims, actions, damages, and liability and expense in connection with loss of life, personal injury or damage to property, arising from or out of the use by Resident of the rented premises or any other of Provider's property, or caused wholly or in part by an act or omission of resident."; and - Liability which read, "Provider is not liable to Resident ... for any injury, death or property damage occurring in the Apartment unit or on Provider's premises unless such injury, death or property damage occurs as the result of an equipment malfunction or hazardous conditions within the building not caused by Residents." On February 1, 2023, at 3:10 p.m., licensed assisted living director (LALD)-C stated the licensee understood the contract included a language waiving licensee's liability. LALD-C stated licensee will update the contract to reflect the acceptable statute language.	0 970		

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0 970	Continued From page 24 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and	01060		

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	29856	A. BUILDING: _____ B. WING _____	02/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HOMESTEAD AT ANOKA	3002 4TH AVENUE NORTH ANOKA, MN 55303

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01060	Continued From page 25 community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation to the resident, legal representative, or designated representative and failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) of the emergency relocation greater than four days for one of one resident (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: R4 was admitted to licensee January 10, 2023, for assisted living services. R4's unsigned service plan printed January 1, 2023, indicated R4 received services to include: registered nurse (RN) comprehensive	01060		

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01060	Continued From page 26 assessment, monitoring and reassessment, laundry assistance, toileting, dressing, bathing, personal hygiene and grooming, transfers, and medication administration. R4's Progress Note dated January 22, 2023, indicated R4 was exhibiting shortness of breath and was taken by emergency medical technicians (EMT) to the hospital. R4 was relocated from the facility for nine days from January 22, 2023, through February 1, 2023. R4's record lacked evidence the licensee provided the resident or resident's representative a written emergency relocation notice as required. On January 1, 2023, at 9:08 a.m., RN-B stated the licensee had not provided to the resident/resident representative or to the ombudsman office the required notices for emergency relocation. RN-B further stated the licensee was not aware of the requirement to do emergency relocation notices, therefore none of the licensee's residents with emergency relocation will have the notification. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted	01620		

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01620	Continued From page 27 as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to conduct an individualized review of residents needs for one of five residents (R2); and failed to ensure the registered nurse (RN) conducted ongoing resident assessment and reassessment, not to exceed 90 calendar days from the last date of the assessment, for three of five residents (R1, R2, R5). 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	01620		

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01620	Continued From page 28 of the residents). The findings include: INDIVIDUALIZED REVIEW R2 R2's diagnoses included type two diabetes mellitus (DM2), major depression, and congestive heart failure. R2's unsigned service plan dated January 30, 2023, indicated R2 received assistance with vital signs, escorts, laundry, bathing, activities of daily living, skilled nursing, medication administration, medication set up, and treatments. R2's Hospice Admission dated November 11, 2021, included oxygen 2 liters (L) as needed for shortness of breath covered by hospice. On January 31, 2023, at 9:11 a.m., the evaluator observed R2 on 2 L of oxygen via nasal cannula. R2's record included two 90-day re-assessments titled Uniform Nursing Assessment - Home Health signed April 25, 2022, and December 6, 2022, which lacked an individualized review of R2's needs related to oxygen usage. The licensee's Initial and Ongoing Resident Evaluations and Assessments dated August 1, 2021, indicated the RN would complete an individualized review by use of the uniform assessment tool which included a list of treatments, including type, frequency, and level of assistance needed. ONGOING ASSESSMENTS R1 R1's diagnoses included mild cognitive	01620		

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01620	Continued From page 29 impairment, muscle weakness, slurred speech, hypertension, and chronic diastolic (congestive) heart failure. R1's service plan signed November 3, 2022, indicated R1 received assistance with toileting, bathing, housekeeping, laundry, and medication administration. On January 30, 2023, at 12:53 p.m., the evaluator observed ULP-E administer two medications to R1. R1's record included two 90-day re-assessments titled Uniform Nursing Assessment - Home Health signed March 14, 2022, and January 30, 2023, which indicated 322 days passed between the March and January assessments. R2 R2's diagnoses included DM2, major depression, and congestive heart failure. R2's unsigned service plan dated January 30, 2023, indicated R2 received assistance with vital signs, escorts, laundry, bathing, activities of daily living, skilled nursing, medication administration, medication set up, and treatments. On January 31, 2023, at 9:24 a.m., the evaluator observed ULP-E administer three medications to R2. R2's record included two 90-day re-assessments titled Uniform Nursing Assessment - Home Health signed April 25, 2022, and December 6, 2022, which indicated 225 days passed between the April and December assessments. R5	01620		

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01620	Continued From page 30 R5's diagnoses included essential hypertension, chronic atrial fibrillation, and other artificial openings of urinary tract status. R5's unsigned service plan printed January 1, 2023, indicated R4 received assistance with transportation, laundry assistance, toileting, dressing, bathing/showering, personal hygiene and grooming, mobility including ambulation and transfers, eating assistance, housekeeping, and medication administration. R5's record included three 90-day re-assessments titled Uniform Nursing Assessment - Home Health dated March 2, 2022, June 27, 2022, and December 7, 2022, which indicated 177 days passed between the March and June assessments and 163 days passed between the June and December assessments. On January 30, 2023, at 10:06 a.m., during entrance conference, RN-B stated assessments were completed before admission or on admission, 14-days after admission, and then every 90-days. RN-B then stated, "the site was behind when I got here. We are in the process of resetting the whole schedule." On February 1, 2023, at 1:54 p.m., RN-A stated they were unaware of why assessments were behind however, "I do know they [assessments] are now all caught up." The licensee's Initial and Ongoing Resident Evaluations and Assessments policy dated August 1, 2021, indicated the RN would complete a nursing assessment using the Uniform Assessment Tool periodically but no less than every 90-days.	01620		

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01620	Continued From page 31 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the current service plan included current services provided and a signature or other authentication by the resident or resident's designated representative and the licensee to document agreement on the	01640		

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01640	Continued From page 32 services to be provided for six of eight residents (R2, R4, R5, R11, R15, R16). 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: R2 R2's unsigned service plan dated January 30, 2023, indicated R2 received assistance with vital signs, escorts, laundry, bathing, activities of daily living, skilled nursing, medication administration, medication set up, and treatments. On January 31, 2023, at 9:24 a.m., the evaluator observed unlicensed personnel (ULP)-E administer three medications to R2. R4 R4's unsigned service plan printed January 1, 2023, indicated R4 received services to include RN comprehensive assessment, monitoring and reassessment, laundry assistance, toileting, dressing, bathing, personal hygiene and grooming, transfers, and medication administration. R5 R5's unsigned service plan printed January 1, 2023, indicated R4 received services to include RN comprehensive assessment, monitoring and reassessment, transportation, laundry assistance,	01640		

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01640	Continued From page 33 toileting, dressing, bathing/showering, personal hygiene and grooming, mobility including ambulation and transfers, eating assistance, housekeeping, and medication administration. R11 R11's unsigned service plan printed January 30, 2023, indicated R11 received assistance with vital signs, escorts, bathing, activities of daily living, housekeeping, medication set-up and reminders, and laundry. On January 31, 2022, at approximately 7:40 a.m., the evaluator observed ULP-E administer morning medications to R11. R15 On January 31, 2023, between 8:27 a.m. and 8:35 a.m., the evaluator observed ULP-E complete vital signs, and medication set up for R15. On February 1, 2023, at approximately 1:35 p.m., the evaluator observed PointClickCare (PCC) (an electronic documentation software system), which indicated R15 lacked a service plan in the system. On February 2, 2023, via email correspondence at 8:47 a.m., the licensee provided the evaluator with R15's service plan printed from PCC on February 2, 2023, after survey was completed and after three attempts to receive the information. R15's unsigned service plan indicated the service plan was initiated on February 1, 2023, and R15 received assistance with medication set-up by a skilled nurse. R16 On January 31, 2023, between 8:27 a.m. and	01640		

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01640	Continued From page 34 8:35 a.m., the evaluator observed ULP-E complete vital signs, and medication set up for R16. On February 2, 2023, via email correspondence at 8:47 a.m., the licensee provided the evaluator with R16's service plan printed from PCC on February 2, 2023, after survey was completed and after three attempts to receive the information. The unsigned service plan indicated R16 received assistance with medication set-up and as needed medication administration. R2, R4, R5, R11, R15, and R16's service plans lacked signature or other authentication by the resident or resident's representative and the licensee to document agreement of all current services provided by licensee. On February 1, 2023, at 2:14 p.m., registered nurse (RN)-A stated all services a resident receives should be on the service plan. In addition, RN-A stated the service plan should be completed and signed by both the resident or resident representative and licensee within 24 hours of initiation of services and may be updated or revised within 14-days of starting services. On February 2, 2023, RN-A stated via email correspondence at 8:47 a.m., R15 and R16's service plans were completed on October 30, 2022, however, "were confirmed yesterday due to a glitch in the system. I do not see a signed copy." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		

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01650	Continued From page 35	01650		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan included all required content for three of five residents (R2, R4, R5).	01650		

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01650	Continued From page 36 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 the potential to affect a large portion or all of the residents). The findings include: R2 On January 31, 2023, at 9:24 a.m., the evaluator observed unlicensed personnel (ULP)-E administer three medications to R2. R2's electronic medication administration record (EMAR) dated January 1, 2023, through January 31, 2023, indicated the licensee provided medication administration at 8:00 a.m., 9:00 a.m., 4:00 p.m., and 8:00 p.m. In addition, the licensee monitored R2's blood glucose at 9:00 a.m. and 4:00 p.m. R2's unsigned service plan dated January 30, 2023, indicated R2 received assistance with vital signs, escorts, laundry, bathing, activities of daily living, skilled nursing, medication administration, medication set up, and treatments. R2's service plan lacked: - a description services to be provided specific to resident's needs; - frequency of each service, according to the resident current assessment and resident preference; - information and a method to contact the facility; and - the names and contact information of persons the resident wishes to have notified in an	01650		

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01650	Continued From page 37 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. R4 R4's unsigned service plan printed January 1, 2023, indicated R4 received assistance with laundry assistance, toileting, dressing, bathing, personal hygiene and grooming, transfers, and medication administration. R5 R5's unsigned service plan printed January 1, 2023, indicated R5 received assistance with transportation, laundry assistance, toileting, dressing, bathing/showering, personal hygiene and grooming, mobility including ambulation and transfers, eating assistance, housekeeping, and medication administration. R4 and R5's service plans lacked the content to include: - frequency of each service, according to the resident current assessment and resident preference; - information and a method to contact the facility; and - 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. On January 31, 2023, at 2:14 p.m., the evaluator inquired what content would be included on the service plan. Registered nurse (RN)-A stated all services provided would be included in the service plan and other content included "I would	01650		

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01650	Continued From page 38 have to review the policy." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure medication was administered as prescribed for one of three residents (R1). 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	01760		

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	29856	A. BUILDING: _____ B. WING _____	02/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HOMESTEAD AT ANOKA	3002 4TH AVENUE NORTH ANOKA, MN 55303

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01760	Continued From page 39 only occasionally). The findings include: OMISSION On January 30, 2023, at 12:53 p.m., the evaluator observed ULP-E administer two medications to R1. R1's diagnoses included mild cognitive impairment, muscle weakness, slurred speech, hypertension, and chronic diastolic (congestive) heart failure. R1's service plan signed November 3, 2022, indicated R1 received assistance with toileting, bathing, housekeeping, laundry, and medication administration. R1's medication administration record (MAR) dated January 1, 2023, through January 31, 2023, indicated staff did not administer the following: - 8:00 a.m. medications which included probiotic pearls, Abreva cream 10 percent (%), Lasix 20 milligrams (mg), lisinopril 10 mg, metoprolol succinate extended release (ER) 50 mg, hydrocortisone cream 1 %, and pilocarpine hcl 5 mg on January 1 and 22; - 12:00 p.m. medications which included potassium chloride ER 20 milliequivalent (MEQ), and pilocarpine hcl 5mg on January 1, 22, and 24; - 2:00 p.m. medications which included aspirin 81 mg, vitamin D 1000 units (u), and senna-s 8.6 mg-50 mg on January 1, 22, 23, and 24; and - 8:00 p.m. medications which included cyanocobalamin 1000 micrograms (mcg), ferrous sulfate 325 mg, ocuvite-lutein capsule, singulair 10 mg, abreva cream 10%, hydrocortisone cream	01760		

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01760	Continued From page 40 1%, senna-s 8.6 mg-50mg, and pilocarpine hcl 5 mg on January 24. R1's MAR indicated the medications were not given and no reason was documented. On February 1, 2023, at 1:51 p.m., registered nurse (RN)-A stated "If staff don't administer medications, it should be documented if the resident had refused. It should be documented why they refused, and the nurse should be updated if it was declined in the MAR. If there is no documentation for omission of medication, we should be checking that on a regular basis and rectifying that by following up with the staff and following up with what happened in that situation." The licensee's Medication Management Services policy dated March 11, 2022, indicated The RN or licensed practical nurse (LPN) will review each resident's medication record when the nurse is setting up medications and at other appropriate times based on the resident's needs and the resident's medication management services, including the resident monitoring visit, to verify that staff is administering the medications as prescribed and is documenting the administration appropriately with authentication by each staff person by discipline or title. TRANSCRIPTION OF PRESCRIBER'S ORDERS R1's prescriber orders dated November 2, 2022, indicated acetaminophen extra strength 500 mg by mouth three times a day. R1's record lacked an order for acetaminophen tablet 500 mg give two tablets by mouth every eight hours as needed for pain. R1's MAR dated January 1, 2023, through January 31, 2023, indicated acetaminophen tablet	01760		

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01760	Continued From page 41 500 mg give two tablets by mouth every eight hours as needed for pain. R1's MAR also indicated daily checks for pain level with a level two being reported on January 2, 3,4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 15, 16, 17, 20, 27, and 30, and a level of zero reported on January 14, 18, 19, 21, 25, 26, 28, and 29. R1's MAR indicated there was no pain level checked on January 1, 22, 23, and 24, and no reason was documented. On January 31, 2023, at 10:53 a.m., RN-B stated, "well I don't know what happened with that order but three times a day and PRN (as needed) three times a day, she [R1] is still getting it [acetaminophen] if she [R1] needs it." On February 1, 2023, at 12:03 pm, RN-A stated there was no discharge order for acetaminophen extra strength 500 mg by mouth three times a day. The licensee's Development of the Individualized Medication Management Plan and Individualized Medication Record policy dated June 12, 2022, indicated the nurse will request a prescription for all legend and over the counter medications and dietary supplements that our agency will be managing and will develop an individualized medication record for each resident, consistent with the resident's medication plan. Any changes in the resident's medications will be addressed in the resident's medication record and communicated to all appropriate staff. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		

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01880	Continued From page 42	01880		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure prescription medications were securely locked in a substantially constructed compartment and permitted only authorized personnel to have access. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On January 30, 2023, from 11:54 a.m. to 12:46 p.m., the evaluator observed the memory care nurse's office door propped open and left unattended as unlicensed personnel (ULP)-E tended to other tasks throughout the memory care unit. During this time, there were five residents in the commons area and one visitor. On January 30, 2023, at 11:57 a.m., the evaluator observed five medication set ups containers which contained several unidentified medications,	01880		

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01880	Continued From page 43 along with multiple unlabeled pharmacy set up punch packs, and over the counter medication bottles. On January 30th, 2023, at 12:46 p.m., ULP-E secured the nurse's office. ULP-E stated, "We usually leave the door unlocked because we don't have a key, so then we have to call someone to unlock it. I just make sure nobody goes in there. They [the residents] don't ever go in there. All of those medications are discontinued, or the resident has passed away. They are from before the changeover, so the nurse just needs to come up and get them and destroy them." On January 30, 2023, at 1:06 p.m., registered nurse (RN)-B stated, "Typically they [staff] don't have access to this room, I actually did not realize they did have access. This used to be the overnight nurse's office but hasn't been used by a nurse for a while now. All these meds are discontinued, and I have been meaning to destroy them but have not had a chance to. I will take these down to the second-floor office where they will be under a double lock until I can destroy them." The licensee's 5.3 Storage and Expiration Dating of Medications, Biologicals policy dated July 21, 2022, indicated the "Facility should ensure that all medications and biologicals, including treatment items, are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		

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01890	Continued From page 44	01890		
01890 SS=E	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure time sensitive medications were labeled with the date opened for two of two residents (R2, R13) with time sensitive medication and failed to ensure a prescription drug was kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label for one of 14 residents (R11). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: DATE OPEN LABEL On January 31, 2023, at 8:35 a.m., the evaluator observed unlicensed personnel (ULP)-F remove an opened Tresiba FlexTouch Solution insulin	01890		

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01890	Continued From page 45 which lacked a date open label in R13's medication cabinet, prepare dose of insulin, administer insulin to R13, and place Tresiba FlexTouch insulin back into the medication cabinet. ULP-F then remove an opened Novolin 70/30 FlexPen which lacked a date open label in R13's medication cabinet, prepare dose of insulin, administer insulin to R13, and place Novolin 70/30 FlexPen back into the medication cabinet. On January 31, 2023, at 9:24 a.m., the evaluator observed ULP-E remove an opened Novolin 70/30 FlexPen which lacked a date open label in R2's refrigerator, prepare dose of insulin, administer insulin to R2, and place Novolin 70/30 FlexPen back into the refrigerator. On February 1, 2023, at 2:43 p.m., registered nurse (RN)-B stated staff were trained to date an insulin pen when opened. The manufacture's guidelines for Novolin 70/30 FlexPen dated November 2019 recommended to dispose Novolin 70/30 FlexPen 28 days after opening and not to refrigerate opened Novolin 70/30 FlexPens. The manufacture's guidelines for Tresiba FlexTouch dated July 2022 recommended once opened, keep Tresiba FlexTouch at room temperature for up to 56 days. The licensee's Storage and Expiration Dating of Medications, Biologicals policy dated July 21, 2022, indicated once a medication or biological package is opened, facility staff should record date opened on the primary medication container when the medication has a shortened expiration date once opened.	01890		

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01890	Continued From page 46 PRESCRIPTION LABEL On January 31, 2023, at 7:38 a.m., the evaluator observed five unlabeled vials of nebulizing solution in R11's locked cupboard. On January 31, 2023, at 7:41 a.m., the evaluator inquired what medication was in the unlabeled vials. ULP-E was unable to tell the evaluator what the medication was. but stated it was the resident's because it was in her cabinet. ULP-E stated the box with information was not in R11's cabinet but the vial was R11's medication because it was located in their cabinet. On February 1, 2023, at 2:09 p.m., RN-A stated they were unsure how staff were trained or the policies on the items listed above. On February 1, 2023, at 1:57 p.m., RN-B stated staff were trained on medication administration during a two-week orientation upon hire, and with a facility trainer. The licensee's Storage and Expiration Dating of Medications, Biologicals policy dated July 21, 2022, indicated the licensee would store medications and biologicals in the container in which they were originally received. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
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	01910		

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01910	Continued From page 47 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 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 (R19). 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:	01910		

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01910	Continued From page 48 R19 was discharged from services September 20, 2022. R19 diagnoses included Parkinson's disease, unspecified dementia without behavioral disturbance, essential hypertension, and other specified anxiety disorder. R19's medication list dated April 19, 2022, indicated R19 was receiving the following medication: amlodipine besylate 5 milligram (mg) take one tablet by mouth, metoprolol succinate 25 mg take one tablet by mouth daily, dorzolamide hcl 2 percent (%)-0.5% instill one drop twice daily into both eyes, and lisinopril 20 mg take one tablet by mouth twice daily. R19's record lacked documentation of the disposition of medications to include name of the medication, strength, prescription number if applicable, quantity, to whom the medications were given, date of disposition, and the names of the staff and other individuals involved in the disposition. On February 1, 2023, at 1:30 p.m., registered nurse (RN)-A stated R19's medication disposition documentation was missing. RN-A also stated that R19 was discharged by another RN who no longer works for the licensee. The licensee's Disposition of Medications Destruction and Disposal policy dated December 2, 2021, indicated licensee will dispose medication in a secure manner in accordance with State and Federal regulations. The policy indicated documentation will include name of the medication, strength, prescription number if applicable, quantity, to whom the medications	01910		

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01910	Continued From page 49 were given, date of disposition, and the names of the staff and other individuals involved in the disposition. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
01940 SS=E	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	01940		

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01940	Continued From page 50 treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop a treatment management plan to include all required content for two of two residents (R2, R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R2 On January 31, 2023, at 9:11 a.m., the evaluator observed R2 on 2 L of oxygen via nasal cannula. R2 stated they used oxygen when they have trouble breathing. R2 admitted to licensee November 1, 2019, under the comprehensive license and started receiving assisted living services August 1, 2021. R2's diagnoses included type two diabetes mellitus (DM2), major depression, and congestive heart failure. R2's Service and Payment Agreement signed October 16, 2019, indicated R2 received as	01940		

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01940	Continued From page 51	01940		

needed assistance with long term care insurance assistance, skilled nursing, home health aide for activities of daily living and mobility, medication set up, medication administration, shower assistance, escort service, and housekeeping.

R2's unsigned service plan dated January 30, 2023, indicated R2 received assistance with vital signs, escorts, laundry, bathing, activities of daily living, skilled nursing, medication administration, medication set up, and treatments.

R2's Hospice Admission dated November 11, 2021, included oxygen 2 liters (L) as needed for shortness of breath covered by hospice.

R2's record included two 90-day re-assessments titled Uniform Nursing Assessment - Home Health signed April 25, 2022, and December 6, 2022, which lacked an individualized review of R2's needs related to oxygen usage.

R2's electronic medication administration record (EMAR) dated January 1, 2023, through January 31, 2023, lacked resident-specific requirements relating to documentation of treatment and therapy received as indicated on the unsigned service plan.

On February 1, 2023, at 1:04 p.m., registered nurse (RN)-A stated hospice provided R2's oxygen and R2 self-administered oxygen.

R5
R5 was admitted to licensee March 11, 2021, under the comprehensive license and started receiving assisted living services August 1, 2021.

R5's diagnoses included essential hypertension, chronic atrial fibrillation, and other artificial

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01940	Continued From page 52 openings of urinary tract status. R5's unsigned service plan printed January 1, 2023, indicated R4 received assistance with transportation, laundry assistance, toileting-change night-to-day and day-to-night bag, dressing, bathing/showering, personal hygiene and grooming, mobility including ambulation and transfers, eating assistance, housekeeping, and medication administration. R5's Uniform Nursing Assessment - Home Health dated March 2, 2022, June 27, 2022, and December 7, 2022, all lacked an individualized review of residents needs related to catheter usage. R2 and R5's treatment plan included templated areas not filled in by the licensee for resident specific information and lacked the following required content for oxygen administration and catheter care: -a statement of the type of services that will be provided; -documentation of specific resident instructions relating to the therapy; and -any resident-specific requirements relating to documentation of therapy received including monitoring of treatment or therapy to prevent possible complications or adverse reactions. On February 1, 2023, registered nurse (RN)- A stated any treatment a resident received would have a treatment and therapy plan with required content. The licensee's Development of Treatment and Therapy Services and Individualized Treatment and Therapy Record policy dated August 1, 2021, indicated the RN would develop an individualized	01940		

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01940	Continued From page 53 treatment and / or therapy management plan for those receiving ordered or prescribed treatment and therapies. In addition, the treatment and/or therapy management plan would include the content listed above. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure documentation of administration or the reason why a treatment was not administered for one of two residents (R5) with treatments. 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	01960		

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01960	Continued From page 54 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 to licensee March 11, 2021, under the comprehensive license and started receiving assisted living services August 1, 2021. R5's diagnoses included essential hypertension, chronic atrial fibrillation, and other artificial openings of urinary tract status. R5's unsigned service plan printed January 1, 2023, indicated R4 received assistance with transportation, laundry assistance, toileting-change night-to-day and day-to-night bag, dressing, bathing/showering, personal hygiene and grooming, mobility including ambulation and transfers, eating assistance, housekeeping, and medication administration. R5's medication administration record dated January 1, 2023, through January 31, 2023, lacked documentation of catheter cares licensee was doing for R5. On February 1, 2023, at 2:10 p.m., registered nurse (RN)-A stated any treatment a resident received would be documented in PointClickCare (PCC) (a software documentation system). The licensee's Development of Treatment and Therapy Services and Individualized Treatment and Therapy Record policy dated August 1, 2021, indicated the treatment and therapy orders, treatments or therapy administration and specific resident instructions were maintained in the	01960		

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01960	Continued From page 55 resident's permanent record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		
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 the observations, document review, and interview, the licensee failed to develop a safety risk assessment plan to identify hazard vulnerabilities and mitigations on and around the property to protect memory care residents from harm. This has the potential to directly affect staff, visitors, and all memory care residents receiving assisted living services. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), and	02040		

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02040	Continued From page 56 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the clients). The findings include: On January 31, 2023, approximately from 11:30 a.m. to 12:15 p.m., survey staff toured the facility with the licensed assisted living director (LALD)-C. At approximately 12:15 p.m., the tour was replaced with the skilled administrator-K until 2:10 p.m. On January 31, 2023, at approximately 3:15 p.m., a document review indicated the license failed to develop a site-specific safety risk assessment and mitigation plan on and around the property to protect the memory care residents from harm. This finding was evident as there was no site-specific plan documentation provided for review and was confirmed during the interview with the LALD-C at 3:15 p.m. On January 31, 2023, at approximately 3:30 p.m., during the exit interview survey staff discussed the observations and explained to the LALD-C that all potential safety risks or vulnerabilities including potential risks of access to the unsecured half open kitchen, sharp objects, and elopement risks on and around the property must be identified, assessed, and mitigated and be documented in the plan documentation to protect the memory care residents from harm. The LALD-C acknowledged the licensee lacked the risk assessment and mitigation plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	02040		

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02040	Continued From page 57 (21) days	02040		
02070 SS=I	144G.81 Subd. 4 Awake staff requirement An assisted living facility with dementia care providing services in a secured dementia care unit must have an awake person who is physically present in the secured dementia care unit 24 hours per day, seven days per week, who is responsible for responding to the requests of residents for assistance with health and safety needs, and who meets the requirements of section 144G.41, subdivision 1, clause (12). This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one or more persons were physically present and available 24 hours a day, seven days a week, who were responsible for responding to requests of residents for assistance in the secured dementia care (memory care) unit. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On January 30, 2023, during the survey, the licensee's census was 75 residents, 69 of whom received services in the assisted living unit, and	02070		

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02070	Continued From page 58 six of whom received services in the memory care unit. The facility consisted of three floors, with a secured memory care located on the third floor. The licensee's staffing plan titled 24 Hour Daily Staffing Schedule dated January 23, 2023, indicated the licensee scheduled two unlicensed personnel (ULP) for the overnight shift. The staff schedule dated January 30, 2023, indicated two ULPs worked the overnight shift, one ULP in the assisted living and one ULP in the memory care unit. The staff schedule dated January 31, 2023, and February 1, 2023, indicated two ULPs were scheduled to work the overnight shift, one ULP in the assisted living and one ULP in the memory care unit. R17's undated Falls Flow Sheet indicated ULP-H and ULP-G discovered R17 on floor of R17's room on the third floor in the assisted living unit after R17 pressed call light. On January 31, 2023, at 7:16 a.m., the evaluator observed the memory care unit without a staff member for one minute when ULP-H exited the memory care unit until 7:17 a.m. On January 31, 2023, at 7:22 a.m., the evaluator inquired if staff leave the memory unit unattended. ULP-H stated, "I usually take my break in there, I don't usually leave, but in an emergency, I do need to leave. I did go off last night to help an emergency, a guy fell last night. Not sure his name but he was just down the hall. There are other people working on the care center side that if we need more people, we can	02070		

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02070	Continued From page 59	02070		

use more people. But it doesn't make sense to call them when we are just right here and can go help quickly. There were only two of us working and the guy wasn't hurt so we just assisted him and then I went right back. It doesn't happen often though, just once in a while."

On January 31, 2023, at 7:25 a.m., ULP-E and ULP-G stated they have left the memory care unit unattended to assist assisted living staff when a fall occurred. In addition, ULP-G stated memory care unit staff also left the unit to assist with a two person transfers or cares because the memory care unit had a low census.

On January 30, 2023, at 10:33 a.m., during the entrance conference, registered nurse (RN)-B stated two ULPs were scheduled to provide resident care on the overnight shift, one ULP was designated in the assisted living and one ULP was designated in the memory care. The surveyor inquired if there were a fall in assisted living in the overnight hours how the licensee would respond. RN-B stated if 911 was not needed, the licensee would utilize the second staff member to assist resident off the floor.

The licensee's Direct - Care Staffing Plan and 24-Hour Daily Staffing Schedule policy dated January 23, 2023, indicated the licensee would develop a staffing plan to determine a staffing level to provide sufficient staffing at all times to meet the scheduled and reasonably foreseeable need of each resident as required by the resident's assessment and service plans on a 24-hour per day basis.

No further information was provided.

TIME PERIOD FOR CORRECTION: IMMEDIATE

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02070	Continued From page 60 Immediacy is removed by evaluation supervisor on January 31, 2023, however noncompliance remains at a scope and severity of I.	02070		
02110 SS=C	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 evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions.	02110		

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02110	Continued From page 61 (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 (ALFDC) were provided to residents or the resident's legal and / or designated representative at the time of move-in for five of five residents (R1, R2, R3, R4, R5). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 admitted to licensee February 14, 2019, under the comprehensive license and started receiving assisted living services August 1, 2021. R2 admitted to licensee November 1, 2019, under the comprehensive license and started receiving assisted living services August 1, 2021. R3 admitted to licensee April 20, 2019, under the comprehensive license and started receiving assisted living services August 1, 2021. R4 admitted to licensee January 10, 2023, for assisted living services.	02110		

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02110	Continued From page 62 R5 admitted to licensee March 11, 2021, under the comprehensive license and started receiving assisted living services August 1, 2021. R1, R2, R3, R4, and R5's resident records lacked evidence a resident or resident representative were provided policies and procedures that addressed 144G.82 Subd. 3. at the time of move-in to the facility. On February 1, 2023, at 2:03 p.m., registered nurse (RN)-A stated the licensee did not have the required policies and procedures for assisted living with dementia care. In addition, RN-A stated the licensee's current policies and procedures for assisted living with dementia care were not provided to residents or resident's families. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02110		
02310 SS=F	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care standards, medical or nursing standards for one	02310		

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02310	Continued From page 63 of two residents (R4) who utilized side rails. 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 February 1, 2023, at 9:44 a.m., in R4's room with licensed assisted living director (LALD)-C, the surveyor observed a bilateral (two sides) side rails on R4's hospital bed. The bedrails shaped rectangular measured approximately 16 inches in width by eight inches in height, the mid-section had vertical bars spaced at approximately four inches apart. R4 was admitted to licensee January 10, 2023, for assisted living services. R4's unsigned service plan printed January 1, 2023, indicated R4 received assistance with laundry assistance, toileting, dressing, bathing, personal hygiene and grooming, mobility-transfers and assistive devices, and medication administration. R4's Informed Choice Consent for Physical Devices signed by both licensee's registered nurse (RN) and the resident representative and dated January 10, 2023, indicated resident was utilizing hospital bed, bed rails, trapeze, and powered wheelchair and the resident was given possible risks of devices.	02310		

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02310	Continued From page 64 R4's record included a Home Health at the Homestead at Anoka-HH Progress Note dated January 22, 2023, indicated R4 was exhibiting shortness of breath and was taken by emergency medical technicians (EMT) to Mercy Hospital where he remained during this survey. R4's record lacked a side rail assessment, and measurements of side rails. On February 1, 2023, at 1:30 p.m., RN-A stated they were unable to locate R4's side rail assessment and measurements. RN-A also stated side rail assessment, measurement and risk versus benefit should be completed initially, annually and after change of condition. The licensee's Physical Devices and Bedrails policy dated January 2010, and revised October 24, 2022, indicated with collaboration of the interdisciplinary team, a physical device data collection tool will be completed on admission, quarterly, annually, and with the initiation of any physical devices by a licensed nurse and then will be reviewed by the interdisciplinary team (IDT) to ensure the safety of the resident utilizing a physical device. The Food and Drug Administration's (FDA) A Guide to Bed Safety, dated 2000, and revised April 2010, indicated following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by	02310		

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02310	Continued From page 65 the patient's health care team will help to determine how best to keep the patient safe." No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	02310		
02320 SS=F	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure unlicensed personnel (ULP) followed appropriate medication administration procedures for three of four employees (ULP-D, ULP-E, ULP-F) observed during medication administration. 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:	02320		

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02320	Continued From page 66 ULP-D ULP-D started employment with licensee October 6, 2015, under the comprehensive license and started to provide assisted living services August 1, 2021. On January 31, 2023, at 7:45 a.m., the evaluator observed ULP-D unlock medication cabinet in R18's room, take medication packet which were labeled with medication name, strength, day of week, and time to be administered out of the cabinet, opened packet, placed medications into a medication cup, and administered amlodipine 5 milligram (mg), losartan potassium 25 mg, guaifenesin 400 mg, omeprazole 20 mg, Tylenol 1000 mg, metoprolol 25 mg extended release (XR), omeprazole 20 mg to R18 without verifying correct medications were administered. On January 31, 2023, at 8:45 a.m., ULP-D stated they attended a medication administration training and completed a medication administration competency prior to passing medications. ULP-D also stated they verify medications in the memory care unit because they have an iPad; however, the licensee provided a computer for the assisted living unit which ULP-D had not learnt to use. In addition, ULP-D stated the licensee changed systems and they no longer verify medications in the assisted living unit because "all meds are set up together with their names and correct doses." The evaluator inquired how ULP-D documented medications administered. ULP-D stated after cares and medications were completed, they would document all medications were received on PointClickCare (PCC) (a documentation software system). ULP-E ULP-E was hired on November 1, 2022, to	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29856	A. BUILDING: _____ B. WING _____	02/01/2023

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THE HOMESTEAD AT ANOKA	3002 4TH AVENUE NORTH ANOKA, MN 55303

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02320	Continued From page 67 provide direct cares and services to residents. ULP-E's record included HHH Medication Training / Skills Record dated November 22, 2021, indicated ULP-E verbalized or demonstrated use of medication administration records and demonstration of the "five rights" of medication administration in a competent manner. On January 31, 2023, at 7:38 a.m., the evaluator observed ULP-E unlock medication cabinet in R11's room, take medication packet which were labeled with medication name, strength, day of week, and time to be administered out of the cabinet, opened packet, placed medications into a medication cup, crushed all medication with the exception of omeprazole 20 mg, and administered amlodipine 5 mg, losartan potassium 25 mg, guaifenesin 400 mg, omeprazole 20 mg, Tylenol 1000 mg, metoprolol 25 mg extended release (XR), Eliquis 5 mg to R11 without verifying correct medications were administered. On January 31, 2023, at 8:06 a.m., the evaluator observed ULP-E unlock medication cabinet in R12's room, take medication packet which were labeled with medication name, strength, day of week, and time to be administered out of the cabinet, opened packet, placed medications into a medication cup, and administered two tablets of carbidopa - levodopa 50 mg / 100 mg, two tablets of lamotrigine 25 mg, and omeprazole 20 mg to R12 without verifying correct medications were administered. On January 31, 2023, at 8:27 a.m., the evaluator observed ULP-E unlock medication cabinet in R15 and R16's room, take a medication packet	02320		

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02320	Continued From page 68	02320		

out for both residents which were labeled with medication name, strength, day of week, and time to be administered out of the cabinet, opened packets, placed medications into separate medication cups which contained potassium 100 mg, senna 8.5, 50 mg, vit d 2000 units (U), levothyroxine 0.25 mg for R15 and levothyroxine 0.1 mg, vit d 2000 U, metoprolol succinate 50 mg for R16, placed medication cups at the dining room table without verifying correct medications were set up appropriately, and left R15 and R16's room.

On January 31, 2023, at 9:24 a.m., the evaluator observed ULP-E unlock medication cabinet in R2's room, removed and opened narcotic box, punched out hydromorphone 1 mg and lorazepam 0.5 mg into medication cup, signed narcotic book, administered the medication listed above to R2 without verifying correct medications were administered. ULP-E stated the medication card provided them instructions of how much medication to administer to R2. In addition, after administration of oral medications, the evaluator observed ULP-E remove Novolin 70/30 FlexPen from refrigerator, prime FlexPen with 2 units (u) of insulin, dialed FlexPen to 25 U, and administered the medication to R2 without verifying correct medication was administered.

On January 31, 2023, at 9:38 a.m., ULP-E stated they attended a medication administration training and completed a medication administration competency prior to passing medications. The evaluator inquired if ULP-E's training included verification of medication prior to medication administration. ULP-E stated they verify medications in the memory care unit because they have an iPad however, the licensee provided a computer for the assisted living unit which was

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02320	Continued From page 69 "to hard to move." In addition, ULP-E stated the licensee changed systems and they no longer verify medications in the assisted living unit because "all meds are set up together." The evaluator inquired how ULP-E documented medications administered. ULP-E stated after cares and medications were completed, they would document all medications were received on PCC. ULP- F ULP-F was hired on December 12, 2012, under the comprehensive license, and began providing direct cares and services on August 1, 2021, under the assisted living license. On January 31, 2023, at 8:00 a.m., the evaluator observed ULP-F unlock medication cabinet in R7's room, take medication packet which was labeled with medication name, strength, day of week, and time to be administered out of the cabinet, opened packet, placed medications into a medication cup, and administered Bumex 1 mg, calcium - vitamin D 500-200 mg, Fosamax 70 mg, methimazole 10 mg, Miralax powder 17 grams (gm), one multivitamin tablet, one ocuvite tablet, quetiapine fumarate 25 mg, senna plus 8.6 mg-50 mg, vitamin D 50 microgram (mcg), sertraline hcl 50 mg, buspirone hcl 30 mg, memantine hcl 10 mg, two tablets of acetaminophen extra strength 500 mg tablets to R7 without verifying correct medications were administered. On January 31, 2023, at 8:15 a.m., the evaluator observed ULP-F unlock medication cabinet in R9 and R10's room, take a medication packet out for both residents which was labeled with medication name, strength, day of week, and time to be administered out of the cabinet, opened packets,	02320		

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	29856	A. BUILDING: _____ B. WING _____	02/01/2023

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02320	Continued From page 70 placed medications into separate medication cups, R9's cup which contained citalopram hydrobromide 20 mg, levothyroxine 137 mcg, metoprolol 50 mg, Eliquis 2.5 mg, R10's cup which included amlodipine besylate 5 mg, aspirin 325 mg, losartan potassium 100 mg, levothyroxine 75 mcg, acetaminophen 1000mg, Carvedilol 25 mg, without verifying correct medications were set up. On January 31, 2023, at 8:27 a.m., the evaluator observed ULP-F unlock medication cabinet in R14's room, take medication packet which was labeled with medication name, strength, day of week, and time to be administered out of the cabinet, opened packet, placed medications into a medication cup, and administered without verifying correct medications were administered. On January 31, 2023, at 8:35 a.m., the evaluator observed ULP-F unlock medication cabinet in R13's room, take medication packet which was labeled with medication name, strength, day of week, and time to be administered out of the cabinet, opened packet, placed medications into a medication cup, aspiring 81 mg, Lasix 20 mg, lisinopril 5 mg, multivitamin tablet, oxybutynin chloride extended release (ER) 5 mg, and administered without verifying correct medications were administered. ULP-F removed an opened Tresiba FlexTouch Solution insulin which lacked a date open label in R13's medication cabinet, prepare dose of insulin, administer insulin to R13, and place Tresiba FlexTouch insulin back into the medication cabinet, and remove an opened Novolin 70/30 FlexPen from R13's medication cabinet, prepare dose of insulin, administer insulin to R13, and placed Novolin 70/30 FlexPen back into the medication cabinet without verifying correct	02320		

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02320	Continued From page 71 medications were administered. On January 31, 2023, at 8:20 a.m., ULP-F stated medications were confirmed by the registered nurse (RN), placed into the medication cabinets and she assumes all medications are correct and does not compare medications to the medication administration record (MAR) before administering. On February 1, 2023, at 1:57 p.m., RN-A stated ULPs were trained on medication administration during orientation, when the licensee changed systems of medication packaging, and if an issue was noticed they would complete "just in time training." On February 1, 2023, at 2:43 p.m., RN-B stated staff were trained to compare the bubble pack information to the electronic medication administration record (EMAR). In addition, RN-B stated the licensee provided tablets for staff to carry with them and were expected to document in "real time" for cares and medication administration. The licensee's Delegation of Nursing Tasks, Medication Administration, Treatment Administration or Therapy Tasks to Unlicensed Personnel policy dated August 1, 2021, read, "The RN must have and maintain a system for delegation of nursing tasks or activities to unlicensed personnel by a registered nurse, including supervision and evaluation of the delegated tasks as required by the Nurse Practice Act in sections 148.71 to 148.285, and the five rights of delegation: - Right task to be delegated - Under the right circumstances - The right person to do the task	02320		

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02320	Continued From page 72 - The right direction and communication - The right supervision to ensure the task is carried out safely." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		

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

Type: Full
Date: *01/30/23*
Time: 12:55:29
Report: 8058231027

Food and Beverage Establishment Inspection Report

Location:
The Homestead At Anoka
3002 4th Avenue North
Anoka, MN55303
Anoka County, 02

Establishment Info:
ID #: 0038280
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7635286500
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.

3-500B Microbial Control: hot and cold holding

3-501.16A2 ** Priority 1 **

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

ITEMS IN REACH IN COOLER AT SERVICE KITCHEN (RIGHT SIDE COOLER) - DO NOT KEEP ITEMS IN THIS COOLER UNTIL THE COOLER HAS BEEN REPAIRED

Comply By: 01/30/23

7-200 Toxic Supplies and Applications

7-201.11A ** Priority 1 **

MN Rule 4626.1600A Separate poisonous or toxic materials from food, equipment, utensils, linens, and single-service and single-use articles by spacing or partitioning.

REMOVE CLEANING CHEMICALS SUCH AS OVEN CLEANER FROM SHELF ABOVE WAREWASHING AREA - COS

Comply By: 01/30/23

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

CFMP IS CURRENTLY EXPIRED

Comply By: 04/30/23

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.

MULTIPLE DAMP CLOTHS LEFT ON COUNTERS - COS

Comply By: 01/30/23

4-500 Equipment Maintenance and Operation

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

REACH IN COOLER IN SERVICE KITCHEN (RIGHT SIDE COOLER) IS NOT MAINTAINING TEMPERATURE - REPAIR OR REPLACE COOLER

Comply By: 02/28/23

Surface and Equipment Sanitizers

Quaternary Ammonia: = 200 PPM at --- Degrees Fahrenheit
Location: DISPENSER
Violation Issued: No

Hot Water: = at 160 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: CUCUMBER
Temperature: 38 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

Process/Item: POTATO
Temperature: 40 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

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

Process/Item: SOUP
Temperature: 168 Degrees Fahrenheit - Location: WARMER
Violation Issued: No

Process/Item: CHICKEN
Temperature: 190 Degrees Fahrenheit - Location: HOT WELL
Violation Issued: No

Process/Item: CHEESE
Temperature: 39 Degrees Fahrenheit - Location: WALK IN
Violation Issued: No

Type: Full
Date: *01/30/23*
Time: 12:55:29
Report: 8058231027
The Homestead At Anoka

Food and Beverage Establishment Inspection Report

Process/Item: DELI MEAT
Temperature: 38 Degrees Fahrenheit - Location: WALK IN
Violation Issued: No

Process/Item: TOMATO
Temperature: 47 Degrees Fahrenheit - Location: REACH IN
Violation Issued: Yes

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

COMMERCIAL KITCHEN

HRD INSPECTOR: BERNARD NYANGENA

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 8058231027 of 01/30/23.

Certified Food Protection Manager: EXPIRED

Certification Number: _____ Expires: / /

Signed: _____
Establishment Representative

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