Electronically Delivered

June 2, 2025

Licensee
Peaceful Lodge
6630 Hudson Boulevard
Oakdale, MN 55128

RE: Project Number(s) SL33424016

Dear Licensee:

On April 28, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on January 31, 2025. 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,

Renee L. Anderson

Renee Anderson, Supervisor
State Evaluation Team
Email: Renee.L.Anderson@state.mn.us
Telephone: 651-201-5871 Fax: 1-866-890-9290

JMD

Electronically Delivered

March 6, 2025

Licensee
Peaceful Lodge
6630 Hudson Boulevard
Oakdale, MN 55128

RE: Project Number(s) SL33424016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 31, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

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

0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $3,000.00
1290 - 144g.60 Subdivision 1 - Background Studies Required - $3,000.00
2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $9,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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

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

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you

may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

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

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

If you have any questions, please contact me.

Sincerely,

Renee Anderson, Supervisor
State Evaluation Team
Email: renee.anderson@state.mn.us
Telephone: 651-201-5871 Fax: 1-866-890-9290

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33424	A. BUILDING: _____ B. WING _____	01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACEFUL LODGE	6630 HUDSON BOULEVARD OAKDALE, MN 55128

(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 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: SL33424016 On January 27, 2025, through January 31, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 71 residents; 71 receiving services under the Assisted Living Facility with Dementia Care license. An immediate correction order was identified on January 28, 2025, issued for SL33424016, tag identification 1290. An immediate correction order was identified on January 29, 2025, issued for SL33424016, tag identification 2310. An immediate correction order was identified on January 30, 2025, issued for SL33424016, tag identification 0775. During the course of the survey, the licensee took action to mitigate the imminent risk of the above	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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 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 evaluators ' 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 SUBDIVISION 1-3.	

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0 000	Continued From page 1 deficiencies. Noncompliance remained and the scope and level remain unchanged.	0 000		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its	0 480		

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0 480	Continued From page 2 existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. 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, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report	0 480		

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0 480	Continued From page 3 (FBEIR) dated January 28, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to establish and maintain an effective infection control program to comply with accepted health care, medical, and nursing standards for infection control. The licensee failed to ensure direct care staff performed adequate hand hygiene (HH) for one of three employees (unlicensed personnel (ULP)-Y). 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	0 510		

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0 510	Continued From page 4 isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-Y was hired November 13, 2024, and provided direct care services to residents. On January 28, 2025, at 7:15 a.m., licensed assisted living director (LALD)-A stated ULP-Y did not speak much English, so LALD-A introduced the surveyor to ULP-Y via translation. On January 28, 2025, during a continuous observation from 7:19 a.m., through 7:33 a.m., the surveyor observed ULP-Y assist R5 with blood pressure (BP) monitoring. Wearing gloves, ULP-Y assisted R5 with BP monitoring using a wrist BP monitor. Without removing gloves and performing HH, ULP-Y touched R5's door handle to exit the room. Next, without removing gloves and performing HH, ULP-Y entered R11's room, assisted R11 with blood glucose testing, and then without changing gloves and performing HH, touched R11's door handle to exit the room. Finally, ULP-Y went to R12's room wearing the same gloves touched the door handle and assisted R12 with BP monitoring using the shared wrist BP monitor. ULP-Y then exited R12's room and went to the secured dementia care unit work area, doffed gloves and completed HH with hand sanitizer. ULP-Y did not clean the shared BP monitor between uses with R5 and R12. On January 28, 2025, at 11:05 a.m., clinical nurse supervisor (CNS)-B stated staff were trained to wash their hands between cares and between residents upon hire and annually. CNS-B also	0 510		

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0 510	Continued From page 5 verbalized the staff should wipe down shared equipment used between residents. The Centers for Disease Control and Prevention (CDC) guidance, CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings, revised November 29, 2022, indicated standard precautions were to be used to care for all patients in all settings to include HH, and noted, "Use an alcohol-based hand rub or wash with soap and water for the following clinical indications: a. Immediately before touching a patient b. Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices c. Before moving from work on a soiled body site to a clean body site on the same patient d. After touching a patient or the patient's immediate environment e. After contact with blood, body fluids or contaminated surfaces f. Immediately after glove removal." The CDC's Healthcare-Associated Infections (HAIs) guidance dated March 19, 2024, indicated in Table 26, Recommended Selection and Care of Noncritical Patient Care Equipment noted to clean and disinfect shared medical equipment before and after each use. The licensee's 8.07 Gloves policy, dated July 1, 2021, indicated "Procedure: 1. Wash hands 2. Apply gloves to both hands 3. Remove contaminated materials 4. Place materials in proper receptacle 5. Remove gloves by grasping cuff of one glove and pulling it off, turning it inside out. With	0 510		

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0 510	Continued From page 6 ungloved hand tuck finger inside cuff of remaining glove and pull off, turning inside out. 6. Dispose used gloves in proper receptacle. 7. Rewash hands." The licensee's 8.09 Hand washing policy dated July 1, 2021, indicated, "Proper hand washing techniques should be used to protect the spread of infection. Hand washing shall be completed: -Before, during, and after preparing food -Before eating food -Before and after caring for someone who is sick -Before and after treating a cut or wound -After using the toilet -After changing diapers or cleaning up after someone who has used the toilet -After blowing your nose, coughing, or sneezing -After touching an animal or animal waste -After handling pet food or pet treats -After touching garbage." In addition, the policy indicated "Hand washing will be performed by all employees, as necessary, between tasks and procedures, and after bathroom use, to prevent cross-contaminations." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact	0 550		

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0 550	Continued From page 7 information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post the required information related to the grievance procedure, including the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances, and the contact information for the Office of Ombudsman for Long-Term Care (OOLTC), the Office of Ombudsman for Mental Health and Developmental Disabilities (OMHDD), and information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC). This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	0 550		

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0 550	Continued From page 8 On January 27, 2025, at 11:10 a.m., during a facility tour with licensed assisted living director (LALD)-A, the surveyor observed the common area in the main entry of the facility where the postings were located. The licensee lacked a posted grievance procedure with the current name, telephone number and email contact information for the individual who was responsible for handling resident grievances. In addition, the licensee failed to have the contact information for the OOLTC, OMHDD, and information for reporting suspected maltreatment to MAARC. On January 27, 2025, at 11:52 a.m., LALD-A stated she did not know why the required information was no longer in the main area of the facility, and she planned to get the required information posted. The licensee's 2.10 Complaint/Grievance Posting policy, dated July 1, 2021, indicated, "1. [Licensee] will post, in a conspicuous place, information about our complaint/ grievance procedure, and the name, telephone number, and email contact information for the individual(s) who are responsible for handling resident complaint/grievances." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 660 SS=D	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	0 660		

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0 660	Continued From page 9 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 observation, interview, and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention and control program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included baseline testing for one of three employees (clinical nurse supervisor (CNS)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a 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: CNS-B was hired on June 12, 2023, and provided direct nursing cares to the licensee residents. On January 27, 2025, at 9:40 a.m., the surveyor	0 660		

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0 660	Continued From page 10 observed CNS-B interacting with an unidentified resident in the nursing office. CNS-B's employee record included a TB history and symptom screening form dated June 13, 2023, indicating no previous adverse reaction to a tuberculin skin test (TST). The record included a QuantiFERON TB Gold Plus test dated November 24, 2022, 200 days prior to hire date. ULP-F's record lacked documentation of a TB blood test or TST completed within 90 days prior to hire date. On January 29, 2025, at 8:30 a.m., licensed assisted living director (LALD)-A stated she would have to speak to the nurse, currently on maternity leave, who keeps record of the TB testing. On January 30, 2025, at 9:42 a.m., CNS-B stated he was not sure if he had a more current TB blood test result. On January 30, 2025, at 10:30 a.m., LALD-A stated the licensee did not have documentation of a TB test completed for CNS-B within 90 days before hire. The licensee's 8.18 Tuberculosis Screening policy dated May 18, 2022, indicated, "[Licensee] will 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 (MMWR)." The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control	0 660		

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	33424	A. BUILDING: _____ B. WING _____	01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACEFUL LODGE	6630 HUDSON BOULEVARD OAKDALE, MN 55128

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0 660	Continued From page 11 in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines indicated, Baseline TB screening consists of three components: 1. Assessing for current symptoms of active TB disease, 2. Assessing TB history, and 3. Testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step TST or single IGRA. Also included, an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record. In addition, HCW with a verbal (undocumented) history of a previous positive TST or IGRA. These HCW's should undergo the same screening procedures as HCW's without previous positive results. Results of the screening should be documented in the HCW's record. If the HCW has documentation of previous treatment for latent TB infection or active TB disease, that documentation may be substituted for documentation of previous positive TST or IGRA results. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=E	144G.42 Subd. 10 Disaster planning and emergency preparedness	0 680		

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0 680	Continued From page 12 (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide the minimum frequency of inspection, maintenance, and load test requirements for the emergency power generator as part of the emergency plan to ensure the proper performance of the generator. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number	0 680		

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0 680	Continued From page 13 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: On January 28, 2025, at 12:30 p.m., the surveyor toured the facility with facilities manager (FM)-S. During the tour interview, FM-S verified the facility had an emergency power generator that was part of the emergency preparedness plan. FM-S stated monthly generator inspections were performed and recorded. On January 29, 2025, FM-S provided inspection and testing records for the generator. Record review indicated the licensee failed to provide the minimum frequency of inspections, maintenance, and load tests to meet the requirements for the emergency power generator as outlined under NFPA 110, (referenced under the Code of Federal Regulations, title 42, section 483.73) as part of the facility's emergency plan required under Minnesota Rules, Part 4659.0100, to ensure proper performance of the generator: -Records for weekly inspections of the generator systems were not provided. -Monthly load test records were not provided. -No records of monthly transfer switch operation tests were provided. TIME PERIOD FOR CORRECTION: Seven (7 days)	0 680		
0 775 SS=I	144G.45 Subd. 2. (a) Fire protection and physical environment	0 775		

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0 775	Continued From page 14 Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to provide required fire protection systems, failed to provide required notification of out of service fire protection systems, and failed to conduct a required fire watch in compliance with Minnesota State Fire Code, under Minnesota Rules Chapter 7511. This had the potential to directly affect all residents, staff, and visitors. 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 28, 2025, at 11:00 a.m., on a facility tour with Oakdale assistant fire chief (OAFC)-U, vice president of operations (VPO)-V, and facilities manager (FM)-S it was observed that the pressure gauge readings were zero for both the wet and dry fire sprinkler systems indicating that they were shut off and out of service. Disabled fire protections systems would not be able to activate in the event of a fire and would not able to provide the required fire protection for the facility.	0 775	During the course of the survey, the licensee took action to mitigate the imminent risk. Noncompliance remained and the scope and level remain unchanged.	

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0 775	Continued From page 15 During an interview, on January 28, 2025, at approximately 11:15 a.m., VPO-V indicated the fire sprinkler system had been out of service on two different occasions recently due to fire sprinkler piping breaks on December 7, 2024, and January 25, 2025. OAFC-U requested fire watch records. VPO-V and FM-S provided fire watch logs, dated December 7, 2024, to December 24, 2024, indicating fire watches were completed every hour. VPO-V stated the licensee had completed a fire watch when the sprinkler systems were out of service from the water break that occurred on December 7, 2024. VPO-V stated the licensee had not completed a fire watch for the out of service sprinkler systems for the water break that occurred on January 25, 2025. VPO-V stated the licensee would immediately start a fire watch and contact the sprinkler contractor to make the emergency repairs immediately. On January 28, 2025, between 12:30 p.m. and 3:05 p.m., the surveyor toured the facility with FM-S. During the tour, it was observed that the gauge for the wet system was pressurized. The pressure gauge readings for the dry system were zero. Behind the front desk in the lobby, the fire alarm control panel display indicated there was a supervisory signal and the dry valve closed. On January 28, 2025, during the facility tour interview, FM-S stated the wet sprinkler system was on and the dry system was still turned off due to repairs that had not been completed. At 3:10 p.m., FM-S provided fire watch records dated January 28, 2025, indicating watches were performed between 12:00 p.m. and 3:00 p.m. Minnesota State Fire Code states that any required fire protection system that is out of service must be reported to the fire department	0 775		

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0 775	Continued From page 16 and fire code official immediately and the building shall be either evacuated or an approved fire watch shall be provided for all occupants left unprotected by the shutdown until the fire protection system has been returned to service. TIME PERIOD FOR CORRECTION: Immediate On January 28, 2025, at 12:30 p.m., the surveyor toured the facility with FM-S. During the tour, the surveyor observed the following: 1. Labeled fire doors were held open with wedges for the front desk reception area and electrical room on the second floor. The door closer's had been removed from both of these doors. All components of a fire door assembly must be maintained as designed. 2. Both labeled fire doors with illuminated exit signs for the stairwell leading to door K were propped open. During the tour interview, FM-S stated these doors were being held open as a result of the repair work being completed in the dementia care units that day. Propping fire doors in the open position prohibits these doors from self-closing and positively latching as designed. 3. An illuminated exit sign was installed above the door leading out to the dementia care patio, enclosed by a fence. The path from the exit door to the fence gate was not maintained free of snow. Additionally, the fence gate was obstructed by items being stored in front of the gate. The exterior exit path from the fence gate to the public right of way was not maintained free of snow. 4. An illuminated exit sign was installed at door G, that lead out to a patio. The exterior exit path from the patio to the public right of way was not maintained free of snow and ice. All paths of egress must provide unobstructed exiting for occupants and access for emergency	0 775		

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0 775	Continued From page 17 responders in the event of an emergency. A means of egress shall be free from obstructions that would prevent its use, including the accumulation of snow. 5. A carbon monoxide alarm was not installed in resident room 213. When carbon monoxide alarms are not tied into the building fire alarm system, carbon monoxide alarms are required to be installed within ten feet of all sleeping rooms. 6. In resident room 203, an extension cord was plugged into a power strip to supply power, creating a fire hazard. During the tour interview, FM-S verified the above listed observations. TIME PERIOD FOR CORRECTION: Two (2) days	0 775		
0 780 SS=D	144G.45 Subd. 2 (a) (1) Fire protection and physical environment for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke	0 780		

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0 780	Continued From page 18 alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that complied with fire protection requirements. This had the potential to directly affect a limited number of residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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 28, 2025, at 12:30 p.m., the surveyor toured the facility with facilities manager (FM)-S. During the tour, the surveyor observed the following: 1. In resident occupied sleeping room 229, a smoke alarm was not installed. The bracket for the smoke alarm was empty. 2. In resident occupied sleeping room 213, the date on the back of the smoke alarm was 2014. Smoke alarms must be replaced every 10 years, or as recommended by the manufacturer.	0 780		

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0 780	Continued From page 19 During the tour interview, FM-S verified the above listed observations. TIME PERIOD FOR CORRECTION: Two (2) days	0 780		
0 790 SS=E	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to install and maintain portable fire extinguishers as required by statute. This deficient condition had the potential to affect more than a limited number of residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).	0 790		

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0 790	Continued From page 20 The findings include: On January 28, 2025, at 12:30 p.m., the surveyor toured the facility with facilities manager (FM)-S. During the tour, the surveyor observed the following: 1. In the dementia care unit on the first floor, a fire extinguisher cabinet identified with a sign was empty. Fire extinguishers must be installed in designated locations. 2. In the dementia care unit on the first floor, the fire extinguisher in the med room was stored on the floor. Fire extinguishers must be available in an emergency and properly installed to prevent them from being moved or damaged. 3. In the elevator room, monthly inspections were not recorded on the tag attached to the portable fire extinguisher between June and September 2024. In the storage room on the main floor, monthly inspections had been recorded on the tag attached to the portable fire extinguisher in May and June 2024. Fire extinguisher inspections must be conducted every month to ensure that each extinguisher is in its designated place, that it has not been tampered with, and that there is no obvious physical damage or condition that would interfere with its use or operation. During the tour interview, FM-S verified the above listed observations. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including	0 800		

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0 800	Continued From page 21 walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On January 28, 2025, at 12:30 p.m., the surveyor toured the facility with facilities manager (FM)-S. During the tour, the surveyor observed the following: 1. There was an active water leak from the ceiling in unoccupied room 214. 2. A ceiling tile was missing in the laundry room by door K. 3. Ceiling tiles were missing in the laundry room and storage area on the main floor. 4. Two of the containers used for smoking	0 800		

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0 800	Continued From page 22 material disposal were disconnected and lying on the ground in two pieces outside. 5. The light fixtures outside the shower area were not working in resident bathrooms for units 127 and 218. 6. The cover for the bathroom light fixture was missing in resident room 215. 7. An electrical wall outlet cover was broken in resident room 213. 8. A wall tile was missing by the shower in resident room 213. During the tour interview, FM-S verified the above listed observations. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be	0 810		

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0 810	Continued From page 23 readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to develop the fire safety and evacuation plan with required content and provide required drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On January 28, 2025, facilities manager (FM)-S provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee FSEP was not developed and maintained relative to the facility's building layout and environmental risks.	0 810		

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0 810	Continued From page 24 The FSEP failed to identify fire protection procedures necessary for residents. The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents evident by a lack of these procedures in the plan. The FSEP shall be developed and maintained to provide efficient communication for exiting in the event of a fire or similar emergency. During an interview, on January 28, 2025, at 3:45 p.m., FM-S verified the FSEP required revision. DRILLS Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month evident by a review of completed fire drill logs. Four fire drills were conducted in 2024, these drills were completed in May, July, and October. Five fire drills were conducted in 2023, these drills were completed in June, July, August, and December. The fire drill reports dated May 29, 2024, and July 31, 2024, recorded 2:00 p.m. as the time for these drills, with 1st and 2nd shifts combined together. The time or shift of the drill was not recorded on any of the other drill logs. The names of the employees who had participated in the drills had not been recorded on all of the fire drill records. During an interview on January 28, 2025, at 3:45 p.m., FM-S verified the evacuation drill frequency was not met and the required drill documentation not recorded. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33424	A. BUILDING: _____ B. WING _____	01/31/2025

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0 830	Continued From page 25	0 830		
0 830 SS=F	144G.45 Subd. 3 Local laws apply Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements, except a facility with a licensed resident capacity of six or fewer is exempt from rental licensing regulations imposed by any town, municipality, or county. This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to submit a Minnesota Department of Health Engineering Services plan review application and obtain local permits for water damage repair work being completed at the facility. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On January 28, 2025, between 11:00 a.m. and 11:30 a.m., the surveyors toured the facility with Oakdale assistant fire chief (OAFC)-U, vice president of operations (VPO)-V, and facilities manager (FM)-S. During the tour, it was observed that repairs were currently being made to the	0 830		

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0 830	Continued From page 26 facility on the second floor. There was a large hole in the ceiling in the room labeled as the living area on the floor plan. During the tour interview, VPO-V and FM-S explained these repairs were being made as a result of a water break that occurred on January 25, 2025. On January 28, 2025, between 12:30 p.m. and 3:05 p.m., the surveyor toured the facility with FM-S. During the tour, it was observed that repairs were currently being made to the facility on the first floor in the secure dementia care unit. Ceiling tiles were missing in the corridor where resident rooms were located. In the dining room, ceiling tiles were missing, light fixtures were hanging loose, electrical outlet covers were not installed, drywall mud was noted on fire sprinklers, floor and wall surfaces were unfinished. Additionally, when the door for room 261 was opened by a person who was exiting the room, it was observed that drywall was being sanded and the air inside the room was filled with a white haze. During the tour interview, FM-S explained these repairs were being made as a result of a water break that occurred on December 7, 2024, and January 25, 2025. During the facility tour interview, FM-S verified a plan review application had not been submitted to Minnesota Department of Health Engineering Services for the repair work. Record review indicated that local building and electrical permits were obtained for the repairs being made as a result of the December 7, 2024 water break. The surveyor requested documentation from FM-S to support that local permits had been obtained for the repairs being made as a result of the January 25, 2025 water break. This documentation was not provided.	0 830		

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0 830	Continued From page 27 TIME PERIOD FOR CORRECTION: Seven (7) days	0 830		
01060 SS=D	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 community-based waiver services under chapter	01060		

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01060	Continued From page 28 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 and failed to notify the Office of Ombudsman for Long-Term Care (OOLTC) of the emergency relocation lasting more than four days for two of four residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: R2 R2 was admitted on July 9, 2024, and began receiving assisted living services. R2's record included a signed service plan dated July 9, 2024. The service plan indicated R2 received services including assistance with grooming, incontinence care and prevention, and	01060		

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01060	Continued From page 29 medication administration. R2's record included a progress note dated January 11, 2025, indicating R2 was transported to the hospital. The progress notes indicated R2 returned from the hospital seven days later, on January 18, 2025. R3 R3 was admitted on September 28, 2023, and began receiving assisted living services. R3's record included a signed service plan dated September 28, 2023, indicating R3 received services including assistance with grooming, dressing, toileting, bathing, transfers, and medication administration. R3's record included a progress note dated September 22, 2024, indicating R3 was transported to the hospital. The progress notes indicated R2 returned from the hospital 9 days later, on October 1, 2024. R2 and R3's record lacked evidence of a written notice provided to the resident, the residents legal representative, designated representative, and OOLTC that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident had been relocated and any new service provider; - contact information for the OOLTC; - if known and applicable, the approximate date or range of dates within which the resident was expected to return to the facility, or a statement that a return date was not currently known; and - a statement that, if the facility refused to provide housing or services after a relocation, the resident had the right to appeal and the contact	01060		

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01060	Continued From page 30 information for the agency to which the resident may submit an appeal. On January 30, 2025, at approximately 8:05 a.m., licensed assisted living director (LALD)-A stated she was not aware of the requirement to provide an emergency relocation notice for residents who were transported to the hospital, or to notify the ombudsman if a resident remained in the hospital for more than four days. LALD-A stated an emergency relocation notice, and notifications were not completed for R2 and R3. The licensee's 1.23 Emergency Relocation policy dated July 1, 2021, indicated, "1. In the event of an emergency relocation, [Licensee] will provide a written notice that contains, at a minimum: a. The reason for the relocation b. The name and contact information for the location to which the resident has been relocated and any new service provider c. Contact information for the Office of Ombudsman for Long-Term Care d. If known and applicable, the approximate date or range of dates within which the resident is expected to return to [Licensee], or a statement that a return date is not currently known, and e. A statement that, if [Licensee] refuses to provide housing or services after a relocation, the resident has the right to appeal. 3. [Licensee] will provide contact information for the agency to which the resident may submit an appeal. 4. The notice required will be delivered as soon as practicable to: a. The resident, legal representative, and designated representative b. For residents who receive home and community-based waiver services, the resident's case manager, and	01060		

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01060	Continued From page 31 c. The Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to [Licensee] within four days." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to obtain a cleared Minnesota Department of Human Services (DHS) background study clearance prior to providing services for fourteen (14) of fourteen employees (cook (C)-C, server (S)-D, S-I, S-K, unlicensed personnel (ULP)-E, ULP-F, ULP-N, ULP-O, ULP-P, custodian (CUS)-M, administrator (A)-G,	01290	During the course of the survey, the licensee took action to mitigate the imminent risk. Noncompliance remained and the scope and level remain unchanged.	

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01290	Continued From page 32 A-H, A-J, A-L). 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: BACKGROUND STUDY ULP-F, A-G, A-H, S-I, A-J, S-K, A-L, CUS-M, ULP-N, ULP-O, ULP-P were hired on January 24, 2012, April 1, 2015, June 1, 2022, July 24, 2023, September 26, 2023, September 9, 2024, October 1, 2010, October 14, 2019, October 16, 2023, December 13, 2017, and December 3, 2024, respectively, and provided direct care and services to the licensee's residents. On January 27, 2025, at 3:15 p.m., A-L provided the surveyor with the licensee's Net Study 2.0 roster. ULP-F, A-G, A-H, S-I, A-J, S-K, A-L, CUS-M, ULP-N, ULP-O, and ULP-P's employee records lacked evidence of a cleared background study, affiliated with the licensee's health facility identification (HFID) on the DHS Net Study 2.0 Roster. COVID-19 STUDY EXPIRED C-C, S-D, and ULP-E were hired on March 1, 2014, December 19, 2021, October 31, 2024, and August 9, 2021, respectively, and provided direct care and services to the licensee's residents. The licensee's Net Study Roster indicated C-C,	01290		

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01290	Continued From page 33 S-D, and ULP-E's Net Study determinations were documented as "Eligible-COVID-19 Study-Expired." C-C, S-D, and ULP-E's employee records lacked evidence of a cleared, current background study on the DHS Net Study 2.0 Roster. On January 27, 2025, at 3:30 p.m., A-L stated it appears the background studies were not updated from the licensee's previous HFID number to the current assisted living HFID number, and was not aware of the COVID-19 study expired results for C-C, S-D, and ULP-E . In addition, A-L verbalized she planned to call Net Study to see what happened and how they could update the employees files. On January 27, 2025, at 4:40 p.m., licensed assisted living director (LALD)-A stated she did not understand why some of the employees were not included on the Net Study roster and she planned to follow up. The licensee's Background Studies policy dated July 1, 2021, indicated, "[Licensee] will conduct a Minnesota Department of Human Services Background Study on all employees and volunteers and contractors at [Licensee]. No employee may provide direct services and have independent direct contact with any residents until acceptable result of the background study have been received. [Licensee] will not employ individuals whose results of the background study indicate disqualification for the position. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01290		

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01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this	01500		

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01500	Continued From page 35 subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employees received at least eight (8) hours of annual training including required content, for each 12 months of employment for one of three employees (clinical nurse supervisor (CNS)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a 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: CNS-B was hired on June 12, 2023, and provided direct nursing cares for residents.	01500		

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01500	Continued From page 36 On January 27, 2025, at 9:40 a.m., the surveyor observed CNS-B interacting with a resident in the nursing office. CNS-B's employee record indicated annual training was completed in April 2024. CNS-B's employee record lacked documentation of the number of hours of annual training completed within the last 12 months, and lacked documentation the following required topics were completed: -training on reporting of maltreatment of vulnerable adults under section 626.557; -review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; -review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. On January 30, 2025, at 9:48 a.m., CNS-B stated he thought he completed some of the annual training. Licensed assisted living director (LALD)-A stated CNS-B did not finish some of the required annual training content. The licensee's 5.06 Annual Required Staff Training policy dated July 1, 2021, indicated, "All	01500		

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01500	Continued From page 37 staff that perform direct care services at [Licensee] will complete at least eight (8) hours of annual training for each 12 months of employment. Also, included "The following training elements MUST be included every 12 months to all staff who performs direct care services: 1. Training on reporting of maltreatment of vulnerable adults under section 626.557 2. Review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights 3. Review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases 4. Effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders 5. Review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures 6. Principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		

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	33424	A. BUILDING: _____ B. WING _____	01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACEFUL LODGE	6630 HUDSON BOULEVARD OAKDALE, MN 55128

(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
01870	Continued From page 38	01870		
01870 SS=D	144G.71 Subd. 18 Medications provided by resident or family me When the assisted living facility is aware of any medications or dietary supplements that are being used by the resident and are not included in the assessment for medication management services, the staff must advise the registered nurse and document that in the resident record. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to identify and document over-the-counter medications in possession of one of one resident (R10). 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: R10's diagnoses included type 2 diabetes with diabetic neuropathy and hypertensive heart and chronic kidney disease without heart failure R10's service plan, printed January 30, 2025, indicated R10 received services including assistance with grooming, dressing, bathing, toileting, and medication administration. R10's nursing assessment dated December 30,	01870		

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PEACEFUL LODGE	6630 HUDSON BOULEVARD OAKDALE, MN 55128

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01870	Continued From page 39 2024, indicated R2 required assistance with medication administration and all R10's medications would be stored in the licensee's secure locked medication cart. R10's record included a Med Admin Summary, dated January 1, 2025, to January 29, 2025, indicating R10 was ordered acetaminophen (for pain) 500 milligrams (mg), take two tablets orally three times daily as needed. The medication summary noted R10 received one dose of acetaminophen on January 10, 2025. On January 28, 2025, at 7:43 a.m., the surveyor observed, with unlicensed personnel (ULP)-R, one bottle of Tylenol (acetaminophen) 500 mg gel capsules on a table next to a small refrigerator in R10's room. ULP-R verbalized R10's family most likely brought it for her, and she would update the nurse. On January 30, 2025, at 8:14 a.m., registered nurse (RN)-Z stated she was not aware R10 had unlocked acetaminophen in her room. -9:06 a.m., RN-Z stated she removed the acetaminophen from R10's room and placed the medication in the licensee's locked medication cart. The licensee's Medication Storage policy, dated July 1, 2021, indicated, "Medications will be stored consistent with each residents' medication management plan and service plan. Medications managed by [Licensee] will be stored to prevent diversion of medications by residents or others who may have access to the medications. Diversion means the misuse, theft, or illegal or improper dispositions of medications. Medications managed outside of a resident's private "living space" must be in securely locked	01870		

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01870	Continued From page 40 and substantially- constructed compartments and permit only authorized personnel to have access. This may be a medication room, medication cart, or similar setup." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01870		
01880 SS=D	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were stored according to manufacturer's instructions for one of three medication refrigerators. 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 27, 2025, at 12:50 p.m., the	01880		

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01880	Continued From page 41 medication refrigerator in the secured dementia care unit of the facility was observed to lack a thermometer and temperature log to document the refrigerator was maintained within the manufacturer recommended range for storage of refrigerated medications. The refrigerator contained three unopened insulin aspart (fast-acting) FlexTouch insulin pens, one unopened insulin glargine (long-acting) Kwikpen, and two unopened insulin lispro (fast-acting) Kwikpen. Manufacturer directions for insulin aspart, insulin glargine, and insulin lispro dated, February 2015, June 2009, and March 2013, respectively, indicated to store unopened pens under refrigeration at 2° to 8° C [Celsius] (36° to 46° F [Fahrenheit]). On January 27, 2025, at 3:15 p.m., clinical nurse supervisor (CNS)-B stated the licensee monitored the medication refrigerators located on the first and second floor of the assisted living area, but he was not aware insulin was being stored in the medication refrigerator located in the secured dementia care unit of the facility. CNS-B also verbalized the temperature of the medication refrigerator in the secured dementia care unit should have been monitored. In addition, CNS-B stated the licensee would begin temperature monitoring of the medication refrigerator located in the secured dementia care unit of the facility. The licensee's Medication Storage policy, dated July 1, 2021, indicated, "When medications are managed and stored by [Licensee], medications will be kept securely locked and stored per manufacturer's directions. Only authorized staff will have access to stored medications."	01880		

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01880	Continued From page 42 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
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 record review and interview, the licensee failed to provide a safety risk assessment or hazard vulnerability assessment of the physical environment on and around the property with mitigation factors. This deficient practice had the ability to affect all dementia care residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	02040		

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02040	Continued From page 43 The findings include: On January 28, 2025, the licensee provided a hazard vulnerability assessment form for the memory care unit dated August 1, 2024. The assessment did not include mitigation of the physical environment hazards. During an interview on January 31, 2025, at 11:00 a.m., licensed assisted living director (LALD)-A stated the licensee had completed a hazard vulnerability assessment form for the dementia care unit and no unmitigated hazards had been identified so mitigation was not included as part of the assessment. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care standards, medical or nursing standards for two of two residents (R7, R8) who utilized hospital style side bedrails and two of two residents (R3, R6) who utilized consumer-style grab bars. This practice resulted in a level three violation (a	02310	During the course of the survey, the licensee took action to mitigate the imminent risk. Noncompliance remained and the scope and level remain unchanged.	

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02310	Continued From page 44 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: HOSPITAL STYLE BED RAILS R7 was admitted on March 19, 2024, and had diagnoses which included congestive heart failure (CHF) (when your heart cannot pump blood effectively), and severe protein calorie malnutrition. R8 was admitted on December 10, 2024, and had diagnoses which included hemiplegia and hemiparesis following cerebrovascular disease affecting right dominant side (weakness, paralysis, and difficulty with balance and movement on one side of the body). On January 28, 2025, at 12:12 p.m., the surveyor observed R7 and R8's bedroom with unlicensed personnel (ULP)-T. R7's bedroom included one hospital-style bed with bilateral (both sides) upper bed rails. Both bed rails were in the upright position. R8's bedroom included one hospital-style bed with bilateral (both sides) upper bed rails. The left bed rail was in the upright position, and the right side rail in the downward position. R7's nursing assessment dated December 25, 2024, indicated under the section labeled "Safety" - "The bed safety zone assessment is not applicable, either resident has no bed rails in use	02310		

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02310	Continued From page 45 or has portable bed rails that are installed on a consumer bed." R8's medical record included a nursing assessment dated December 24, 2024, which indicated under the section labeled "Safety" - "The bed safety zone assessment is not applicable, either resident has no bed rails in use or has portable bed rails that are installed on a consumer bed." R7 and R8's medical records lacked: -assessment for appropriateness and safe use of bed rails; -documentation of education and discussion with resident or their representative of risks and benefits of bed rails; and -documentation of measurements of Food and Drug Administration (FDA)-identified zones of entrapment. CONSUMER-STYLE PORTABLE BED RAILS R3 R3 was admitted on September 28, 2023, and had diagnoses which included hemiplegia/hemiparesis following cerebrovascular accident (CVA), and mood disturbances. On January 27, 2025, at 1:48 p.m., the surveyor observed R3's bedroom with ULP-R. R3's bed included a "M" shaped portable bed rail on the left side of R3's bed. On January 29, 2025, at 9:55 a.m., the surveyor again observed R3's bedroom, with clinical nurse supervisor (CNS)-B. R3's "M" shaped portable bed rail was secured by insertion beneath the mattress on the right side of R3's bed. R3's nursing assessment dated December 5,	02310		

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02310	Continued From page 46 2024, indicated under the section labeled "Safety - Bed Safety", - "Uses bed rails for stabilization support to transfer in/out of bed to prevent falls due to unsteady gait related to CVA". R6 R6 was admitted on February 1, 2021, and had diagnoses which included dementia (memory loss) and high blood pressure. R6's nursing assessment dated December 24, 2024, indicated under the section labeled "Safety" - "The bed safety zone assessment is not applicable, either resident has no bed rails in use or has portable bed rails that are installed on a consumer bed." Also, noted, "[R6] does not have a hospital bed system. She has tuck under the mattress bed rail only." The licensee lacked evidence the consumer-style portable bed rails were installed and maintained per manufacturer guidelines and evidence the licensee ensured the bed rails were not recalled by the Consumer Product Safety Committee (CPSC). On January 29, 2025, at 10:25 a.m., clinical nurse supervisor (CNS)-B stated the licensee did not have a process to identify when a resident used a hospital style or consumer style bed rail other than when the nurse would go to the residents room and make the observation. CNS-B also stated they had not completed bed rail assessments with measurements of entrapment zones for R7 and R8. CNS-B verbalized he was not aware R7 had a hospital style bed rail and R8's family recently brought her a new bed and he had not had a chance to complete the assessment. Finally, CNS-B verbalized a side rail assessment with measurement in the zones of	02310		

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02310	Continued From page 47 entrapment had not been completed for R7 ad R8. On January 29, 2025, at 10:35 a.m., CNS-B stated the licensee was not aware of the manufacturer of the consumer-style bed rails, the requirement to follow manufacturer directions on installation and maintenance of the bed rails, nor how to use the CPSC website to check for recalls. CNS-B stated he planned to implement a new process on how the nurse assessed bed rails of all types. The licensee's Assessing the Safety of Side Rails policy dated July 1, 2021, indicated, "When [Licensee] is aware a home care resident is utilizing side rails (a medical device) on a bed, [Licensee] will assess the use, educate the resident, and when appropriate, the responsible person, regarding the risks and benefits of side rails, and verify that the side rail in use is of a safe design and utilized consistent with the manufacturer's directions. This policy shall be followed regardless of who owns or is supplying the side rail." In addition, included, "When side rails are in use, an RN must conduct an assessment to identify the intended purpose of the side rail and the risks regarding the use of the side rail. If the side rail is acting as a restraint, appropriate action should be taken." The Food and Drug Administration (FDA)'s, A Guide to Bed Safety, dated March 10, 2006, included the 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,	02310		

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02310	Continued From page 48 uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently Asked Questions (FAQs), last updated December 12, 2024, indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment: - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Installation and use according to manufacturer's guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements."	02310		

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02310	Continued From page 49 In addition, included, ""If a licensee is unable to locate manufacturer's guidelines, they are unable to assess and determine if the portable bed rail is being used appropriately and installed properly." No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	02310		

Minnesota Department of Health
Division of Environmental Health, FPLS
PO Box 64975
Saint Paul, 55164-0975
651-201-4500

Type: Full
Date: *01/28/25*
Time: 11:12:16
Report: 1023251037

Food and Beverage Establishment Inspection Report

Location:
Peaceful Lodge
6630 Hudson Boulevard
Oakdale, MN55128
Washington County, 82

Establishment Info:
ID #: 0039147
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6512075769
ID #:

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

The following orders were issued during this inspection.

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

3-304.12F

MN Rule 4626.0275F Discontinue storing food preparation or dispensing utensils in a container of water that is not maintained at 135 degrees F (57 degrees C) and not cleaned when empty.

OPERATOR STORING RICE SCOOP IN ROOM TEMP WATER.

Comply By: 01/28/25

4-100 Equipment Construction Materials

4-101.17

MN Rule 4626.0490 Discontinue using wood and wood wicker as a food contact surface.

WOODEN UTENSILS STORED IN FACILITY. OPERATOR DISCARDED DURING INSPECTION.

Comply By: 01/28/25

4-200 Equipment Design and Construction

4-201.11BMN

MN Rule 4626.0506B Provide an exhaust ventilation hood that meets the requirements in the Minnesota Mechanical Code, Minnesota Rules, chapter 1346.

HAVE VENTILATION HOOD PROFESSIONALLY DEGREASED AS NEEDED. POST VERIFICATION OF MOST RECENT CLEANING.

Comply By: 01/28/25

6-200 Physical Facility Design and Construction

6-202.18

MN Rule 4626.1410 Provide overhead protection for outdoor servicing areas.

OPERATOR CURRENTLY TRANSPORTING FOOD OUTSIDE FROM MAIN KITCHEN TO MEMORY CARE UNIT. FOOD TRANSPORTED OUTSIDE MUST BE FULLY COVERED/ENCLOSED DURING TRANSIT.

Comply By: 01/28/25

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.11

MN Rule 4626.1515 Maintain the physical facilities in good repair.

CRACKED FLOOR AND HOLE IN WALL IN BACK DRY STORAGE AREA.

Comply By: 01/28/25

Surface and Equipment Sanitizers

Quaternary Ammonia: = 200PPM at Degrees Fahrenheit
Location: SANI BUCKET
Violation Issued: No

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

Hot Water: = at 161 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Hold/HAM
Temperature: 40 Degrees Fahrenheit - Location: PREP COOLER
Violation Issued: No

Process/Item: Cold Hold/MILK
Temperature: 41 Degrees Fahrenheit - Location: REACH IN COOLER
Violation Issued: No

Process/Item: Cold Hold/CHICKEN
Temperature: 40 Degrees Fahrenheit - Location: WALK IN COOLER
Violation Issued: No

Process/Item: Cooking/CHILI
Temperature: 178 Degrees Fahrenheit - Location: ON RANGE
Violation Issued: No

Type: Full
Date: *01/28/25*
Time: 11:12:16
Report: 1023251037
Peaceful Lodge

Food and Beverage Establishment Inspection Report

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	0	0	5

THIS INSPECTION WAS CONDUCTED IN CONJUNCTION WITH MDH HEALTH REGULATORY DIVISION (HRD) SURVEY. INSPECTION CONDUCTED IN PRESENCE OF THE PERSON IN CHARGE.

THIS FACILITY HAS A MAIN KITCHEN WITH COOK LINE UNDER TYPE I HOOD WITH SUPPRESSION, DISH MACHINE, THREE COMPARTMENT SINK, PREP SINK, AND ALSO HAS A SERVING AREA IN MEMORY CARE UNIT. FOOD SERVICE IS PROVIDED BY FACILITY STAFF.

THESE TOPICS WERE DISCUSSED WITH THE PERSON IN CHARGE:
- EMPLOYEE ILLNESS EXCLUSION
- HAND WASHING PROCEDURE
- NO BARE HAND CONTACT WITH RTE FOOD
- VOMIT CLEAN UP PROCEDURE
- FULLY COOKING FOOD FOR HIGH RISK POPULATIONS

MEMORY CARE SERVICING KITCHEN CLOSED DUE TO DINING ROOM RENOVATIONS DURING THIS VISIT.

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 1023251037 of 01/28/25.

Certified Food Protection Manager: XIONG KONG

Certification Number: 75108 Expires: 03/13/27

Inspection report reviewed with person in charge and emailed.

Signed: _____

XIONG KONG
PERSON IN CHARGE

Signed: Gregory T Nelson

Gregory T. Nelson
Public Health Sanitarian
Freeman Building
651-201-4259
greg.nelson@state.mn.us