



Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF REMOVAL OF CONDITIONAL LICENSE

Electronic Delivery

July 25, 2024

Licensee
Atlas Villas Memory Care
1825 Main Street
Centerville, MN 55038

RE: Initial License Number 411260
Health Facility Identification Number (HFID) 39714
Project Number(s) SL39714015

Dear Licensee:

On July 2, 2024, The Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed February 29, 2024. The follow-up survey found the facility to be in substantial compliance. Based on these findings, the condition(s) on the license were removed effective 07/02/2024.

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

This is your **official notice** that you have been **granted your assisted living facility license with dementia care**. Your license effective and expiration dates remain the same as on your provisional license. Your updated status will be listed on the license certificate at renewal and **this letter serves as proof** in the meantime. If you have not received a letter from us with information regarding renewing your license within 60 days prior to your expiration date, please contact us at (651) 201-5273 or by email at Health.assistedliving@state.mn.us.

Furthermore, the follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the February 29, 2024, initial survey.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a), state correction orders issued pursuant to the last survey completed on February 29, 2024, found not corrected at the time of the follow-up survey follow-up survey and/or subject to a penalty assessment are as follows:

0650-Employee Records-144g.42 Subd. 8

The details of the violations noted at the time of this follow-up survey completed on July 2, 2024 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Also, at the time of this follow-up survey completed on July 2, 2024, we identified the following violation(s):

1360-Instructor And Competency Evaluation Requirem-144g.61 Subdivision 1

The details of the violation(s) noted at the time of this follow-up survey are delineated on the attached State Form. Only the ID Prefix Tag in the left hand column without brackets will identify these state correction orders. It is not necessary to develop a plan of correction.

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

DOCUMENTATION OF ACTION TO COMPLY

Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document 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>

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

Sincerely,



Rick Michals, J.D.
Interim Assistant Division Director

**Minnesota Department of Health
Health Regulation Division**

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39714	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 07/02/2024
NAME OF PROVIDER OR SUPPLIER ATLAS VILLAS MEMORY CARE			STREET ADDRESS, CITY, STATE, ZIP CODE ATLAS VILLAS MEMORY CARE CENTERVILLE, MN 55038		
(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 In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been 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: SL39714015-1 On July 1, 2024, through July 2, 2024, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on February 29, 2024. At the time of the survey, there were 13 residents; 13 receiving services under the provisional Assisted Living with Dementia Care license. As a result of the follow-up survey, the following orders were issued/reissued.	{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.		
{0 650} SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of	{0 650}			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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{0 650}	Continued From page 1 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 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 the employee record contained the required content for one of five employees (unlicensed personnel (ULP)-M). 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).	{0 650}			

Minnesota Department of Health

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{0 650}	Continued From page 2 The findings include: ULP-M was hired on May 1, 2024, to provide services to the licensee's residents. ULP-M's training record lacked documentation of training and evidence of demonstrated competency on the following: -reports of changes in the resident's condition to the supervisor designated by the assisted living provider; -maintenance of a clean and safe environment; -appropriate and safe techniques in personal hygiene and grooming, including: -hair care and bathing, -care of teeth, gums, and oral prosthetic devices, -care and use of hearing aids, -dressing and assisting with toileting; -standby assistance techniques and how to perform them; -awareness of commonly used health technology equipment and assistive devices (competency only); -basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes; -reading and recording temperature, pulse, and respirations of the resident (competency only); -recognizing physical, emotional, cognitive, and developmental needs of the resident; -safe transfer techniques and ambulation (competency only); -range of motioning, and positioning (competency only); -administering medications or treatments as required (competency only); -other RN/professionally delegated tasks; -compression stocking (competency only); and	{0 650}			

Minnesota Department of Health

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{0 650}	Continued From page 3 -oxygen therapy (competency only). On July 2, 2024, at 11:29 a.m., licensed assisted living director (LALD)-B could not locate ULP-M's training records but stated clinical nurse supervisor (CNS)-K did complete the required training for ULP-M. The licensee's 4.05 Employee Records policy effective June 1, 2022, indicated employee records for each person would include records of all training and in-service education required and/or provided including record of competency testing as required. The licensee's 5.02 Competency Training Evaluations policy effective June 1, 2022, indicated a copy of all education, training, and competency testing on the above content shall be kept in each employee's personnel file. No further information provided.	{0 650}			
{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	{0 810}			

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{0 810}	Continued From page 4 evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: No further action required.	{0 810}			
01360 SS=F	144G.61 Subdivision 1 Instructor and competency evaluation requirem Instructors and competency evaluators must meet the following requirements: (1) training and competency evaluations of unlicensed personnel who only provide assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), must be conducted by individuals with work experience and training in providing these services; and (2) training and competency evaluations of unlicensed personnel providing assisted living services must be conducted by a registered	01360			

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01360	Continued From page 5 nurse, or another instructor may provide training in conjunction with the registered nurse. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a registered nurse (RN) provided training and competency evaluations of unlicensed personnel (ULP) providing assisted living services for five of five employees (lead unlicensed personnel (LULP)-B, ULP-E, ULP-F, ULP-L, ULP-M). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On July 1, 2024, at 12:50 p.m., LULP-B stated she provided training to ULPs by going over the policies and provided them with quizzes to complete. LULP-B stated if an answer was incorrect on the quiz, they would go over the content of the policy until it was answered correctly. LULP-B stated in order to pass the knowledge competency, all answers had to be correct. On July 2, 2024, at 9:45 a.m., co-owner/licensed assisted living director (O/LALD)-D stated they were informed by consultant (C)-N while working with them that LULP-B was able to provide training on certain topics. O/LALD-D stated she contacted C-N that morning and was told it wasn't	01360			

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01360	Continued From page 6 right and must've missed that. On July 2, 2024, at 10:51 a.m., the surveyor observed LULP-B and ULP-E assist R3 with the following: apply compression stockings to both legs, transfer R3 from bed to wheelchair using a mechanical sit to stand lift, assist with toileting, dressing, and grooming, and administer medications. On July 2, 2024, at 11:11 a.m., ULP-E stated when LULP-B completed training with her, LULP-B went over the content then took the quiz. LULP-B was hired on May 15, 2023, to help with staff scheduling, compliance, and provide services to licensee's residents. ULP-E, ULP-F, ULP-L, and ULP-M were hired on January 2, 2024, July 20, 2023, April 29, 2024, and May 1, 2024, respectively, to provide services to licensee's residents. LULP-B's training record dated April 26, 2024, indicated O/LALD-D provided training and competency to LULP-B on the following topics: -clean and safe environment; -recognizing physical, emotional, cognitive, and developmental needs of the resident; -observation, reporting, and documenting of resident status; -documentation requirements for all services provided; and -basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel. ULP-E's training record dated April 25-26, 2024, indicated LULP-B provided training and	01360			

Minnesota Department of Health

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01360	Continued From page 7 competency to ULP-E on the following topics: -clean and safe environment; -recognizing physical, emotional, cognitive, and developmental needs of the resident; -observation, reporting, and documenting of resident status; -documentation requirements for all services provided; and -basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel. ULP-F's training record dated September 9, 2023, indicated LULP-B provided training and competency to ULP-F on the following topics: -clean and safe environment; -communication and professional boundaries; and -basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel. ULP-L's training record dated May 30, 2024, indicated LULP-B provided training and competency to ULP-L on the following topics: -clean and safe environment; -recognizing physical, emotional, cognitive, and developmental needs of the resident; -observation, reporting, and documenting of resident status; and -documentation requirements for all services provided. ULP-M's training record dated June 2, 2024, indicated LULP-B provided training and competency to ULP-L on the following topics: -clean and safe environment; -recognizing physical, emotional, cognitive, and	01360			

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01360	Continued From page 8 developmental needs of the resident; -documentation requirements for all services provided; and -basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel. The licensee's 5.02 Competency Training Evaluations policy dated June 1, 2022, indicated when a registered nurse or licensed health professional staff of [licensee] delegates tasks, prior to the delegation of services they must make certain the ULP is trained in the proper methods to perform the tasks or procedures for each [resident] and are able to demonstrate the ability to competently follow the procedures and perform the tasks. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01360			
{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.	{02040}			

Minnesota Department of Health

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{02040}	Continued From page 9 This MN Requirement is not met as evidenced by: No further action required.	{02040}			



Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF PROVISIONAL EXTENSION AND CONDITIONAL LICENSE

Electronically Delivered

April 3, 2024

Licensee
Atlas Villas Memory Care
1825 Main Street
Centerville, MN 55038

RE: Provisional Conditional License Number 411260
Health Facility Identification Number (HFID) 39714
Project Number(s) SL39714015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on February 29, 2024, for the purpose of assessing compliance with state licensing statutes. Based on the survey results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, pursuant to Minn. Stat. § 144G.16, Subd. 3(b)(2), MDH is extending the provisional license for 90-days and applying conditions necessary to bring the facility into substantial compliance. The provisional license extension and conditions are due to expire **July 2, 2024**.

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. MDH documents state 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 . . ."

MDH may assess fines based on the level and scope of the orders outlined below. The total amount of **potential** fines that may be assessed related to these correction orders is \$3,000.00. **MDH is not imposing these fines against your provisional license at this time.**

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the provisional 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. **If corrections are not made, MDH may impose fines as described above and in accordance with Minnesota Statutes 144G.**

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.

A state correction 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.

To submit a reconsideration request, please visit:

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

CONDITIONAL LICENSE ISSUED:

MDH will issue Atlas Villas Memory Care a conditional provisional assisted living facility license for 90 calendar days from the date of this notice. At an unannounced point in time, within the 90 calendar days, MDH will conduct a follow-up survey, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the follow-up survey, MDH will determine if Atlas Villas Memory Care is in substantial compliance.

The following conditions apply on the conditional provisional assisted living facility license:

- a. No new substantiated maltreatment allegations:** If any new investigations begin in the conditional provisional license period, and the allegations are substantiated, MDH may pursue additional enforcement actions up to and including immediate temporary suspension and revocation of the provisional license.
- b. No new admissions:** Atlas Villas Memory Care will not admit any new residents under its conditional provisional assisted living facility license until MDH removes the "no new admissions" condition. Atlas Villas Memory Care

must provide the Department:

- i. A list of the names and birthdates of any individuals Atlas Villas Memory Care is currently in the process of admitting. These individuals will be able to continue the admittance process.
 - ii. A list of all current residents by location including:
 - 1. Name and birthdate of each resident
 - 2. Physical location of each resident
 - 3. Current payment source for services
 - 4. If Elderly Waiver, the name and contact information of the care coordinator/case manager
 - 5. If the resident is not able to make informed decisions, the name of their representative and how to contact the representative
- c. **Consultant:** Atlas Villas Memory Care will contract with an RN to provide consultation concerning all resident(s) to whom Atlas Villas Memory Care provides provisional licensed assisted living services under the conditional license. The consultant must have access to all resident(s) receiving services from Atlas Villas Memory Care. The consultant will conduct initial and ongoing evaluations of the provider. Direct resident observation may be required based on the consultant's judgement or at the discretion of MDH. The RN must not have any affiliation with Atlas Villas Memory Care and MDH must review the RN's credentials and approve the selection. Atlas Villas Memory Care is responsible for the expense of the contract with the RN. The main purpose of the consultant is to provide guidance to Atlas Villas Memory Care in an effort to help Atlas Villas Memory Care align their practices with the requirements of Minn. Stat. §§ 144G.01 – 144G.9999 and to provide oral and written reports to MDH noting progress toward substantial compliance and/or concerns about observations. Atlas Villas Memory Care will develop and implement policies, procedures, and processes specific to the offered services in accordance with the guidance provided by the consultant to ensure ongoing monitoring and substantial compliance with statutory requirements.
- d. **Reports:** The RN consultant will provide MDH with regular reports at intervals specified by MDH. Reports will begin on a weekly basis until MDH notifies Atlas Villas Memory Care and the RN consultant about a change. Each report will be electronically submitted to Jess Schoenecker, Survey Supervisor, State Evaluation Team, Health Regulation Division, at jess.schoenecker@state.mn.us. Jess Schoenecker can be reached at 651-201-3789 (office) with questions about reports. The content of the reports will include information such as:
- i. Progress towards correction of orders;
 - ii. Observations of staff delivering assisted living services and the level of competency observed;

- iii. Conversations with residents and family members about satisfaction with assisted living services;
 - iv. Conversations with staff about their level of knowledge about the tasks they perform, the people they serve and the health professionals who delegate to them;
 - v. Overall impressions about the quality of the assisted living services delivered;
 - vi. Overall impressions about the dignity with which the residents and their family members are treated;
 - vii. Concerns; and
 - viii. Any other information requested by the Department or considered important by the RN consultant(s).
- e. **Monitoring visits:** MDH may make unannounced monitoring visits to assess the progress of Atlas Villas Memory Care to correct the violations cited during the survey as well as to determine the overall practice of Atlas Villas Memory Care in meeting the needs of the people it serves. In addition, the Office of Ombudsman for Long-Term Care (OOLTC) may also make unannounced monitoring visits to determine the level of satisfaction of those people who receive provisional licensed assisted living services. The OOLTC will share their findings with MDH.
- f. **Follow-up survey:** At the time of the follow-up survey, MDH may pursue additional enforcement actions, up to and including immediate temporary suspension or revocation of the provisional license if MDH identifies any level 3 or 4 violations or widespread care related violations.
- g. **Corrective Action Plan:** Atlas Villas Memory Care will develop and work within a corrective action plan (CAP). The CAP is a working document that includes at least the following information:
- i. A statement of the concern
 - ii. A description of what will happen to correct the concern
 - iii. A target date for when each correction will be complete
 - iv. Who is responsible to make sure it happens
 - v. Current status of correction work
 - vi. Description of a plan to monitor and ensure ongoing substantial compliance for each corrected order

RESULTS OF FOLLOW-UP EVALUATION DURING THE CONDITIONAL PROVISIONAL LICENSE PERIOD:

MDH will determine if Atlas Villas Memory Care is in substantial compliance based on the results of the follow up survey. MDH will make this determination within the 90-day conditional provisional license period. If MDH determines Atlas Villas Memory Care is in substantial compliance on the follow up survey, MDH will remove the conditions and grant the assisted living facility license to Atlas Villas Memory Care. If MDH determines Atlas Villas Memory Care is not in substantial compliance, MDH may deny the license pursuant to Minn. Stat. § 144G.16, Subd. 3 (b) (2).

REQUEST FOR RECONSIDERATION:

Pursuant to Minn. Stat. §144G.16, Subd. 4, if a provisional licensee whose assisted living facility license has been denied, or extended with conditions, disagrees with the action taken against the provisional license under this section, the provisional licensee may request a reconsideration no later than 15 calendar days after provisional licensee receives notice of the action. **This is your only ability to request a reconsideration under this enforcement action.**

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

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 Jess Schoenecker directly at: 651-201-3789 .

Sincerely,

A handwritten signature in black ink that reads "Rick Michals". The signature is written in a cursive, flowing style.

Rick Michals, J.D.
Interim Assistant Division Director

**Minnesota Department of Health
Health Regulation Division**

PMB

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39714	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/29/2024
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0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL39714015-0 On February 26, 2024, through February 29, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 16 residents receiving services under the Provisional Assisted Living with Dementia Care license. On February 27, 2024, an immediate correction order was issued for tag identification number 2310. On February 28, 2024, the immediacy of the order was removed based on supervisory review. Noncompliance remains and the scope and level remain unchanged.	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 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.		
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a	0 250			

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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0 250	Continued From page 1 result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under	0 250			

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0 250	Continued From page 2 section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required with records reviewed. This had the potential to 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, 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: On February 26, 2024, at approximately 10:00 a.m., licensed assisted living director (LALD)-D	0 250			

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0 250	Continued From page 3 stated they were familiar with the assisted living regulations and the licensee provided dementia care, medication and treatment management, and hands on assistance for all residents. The licensee's Application for Provisional Assisted Living License, section titled Assisted Living Facilities with Dementia Care Requirements, indicated licensee did not have experience managing residents with dementia. Pursuant to Minn. [Minnesota] Stat. [statute] sect. [section]144.80, subd. [subdivision] 2 (b), the applicant must employ a consultant. The consultant must have two years of work experience related to dementia care and must be employed for at least the first six months of operation. The consultant must meet the training requirements for staff as mentioned in 144G.64 and applicable rules Minnesota Rules, chapter 4659. The licensee's Application for Provisional Assisted Living License, section titled Official VG80erification of Owner or Authorized Agent, (page four and five of the application), identified, I certify I have read and understand the following: [a check mark was placed before each of the following]: - I have read and fully understand Minn. Stat. sect. 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17. - I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if	0 250			

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0 250	Continued From page 4 applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G. - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659. - Reporting of Maltreatment of Vulnerable Adults. - Electronic Monitoring in Certain Facilities. - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of	0 250			

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0 250	Continued From page 5 a provisional license or license. All data submitted are considered private until MDH issues a license. - I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. - I have examined this application and all attachments and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify the MDH, in writing, of any changes to this information as required. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page eighteen (18) was electronically signed by LALD-D on November 8, 2022. The licensee had an assisted living license issued on February 23, 2023, with an expiration date of February 27, 2024. The licensee failed to ensure the following policies and procedures were developed and/or implemented:	0 250			

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0 250	Continued From page 6 - orientation and a process for evaluating staff performance; - conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; and - medication and treatment management. On February 29, 2024, at 12:45 p.m., LALD-D stated she understood the deficiencies and would work on getting them corrected right away. As a result of this survey, the following orders were issued: 0250, 0510, 0650, 0680, 0810, 0910, 0970, 1440, 1470, 1540, 1620, 1650, 1770, 1940, 2040, 2110, and 2310. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250			
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	0 510			

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0 510	Continued From page 7 assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program that complied with accepted health care, medical and nursing standards for infection control related to gloves and surfaces for one of two unlicensed personnel ((ULP)-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a 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: During observations on February 27, 2024, between 8:35 a.m., through 9:00 a.m., with gloves on, ULP-F administered throat numbing medication to R4, then with same gloves, charted on a paper medication administration record (MAR), removed gloves, then charted on the electronic medication administration record (eMAR) without hand hygiene. At 8:50 a.m., without hand hygiene, ULP-F set up an oral medication from the narcotic box within the nursing office, went into R7's room, applied gloves. Within R7's room, ULP-F opened the medication cabinet with keys and grabbed Miralax (medication for bowels) and poured it into	0 510			

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0 510	Continued From page 8 a medication cup, locked the cabinet with keys and realized there wasn't any water cups, so ULP-F locked the medications in the cabinet, removed gloves and left the room to grab water cups. Upon re-entry of R7's room, ULP-F applied gloves, and retrieved the medications and administered them to R7 while sitting on the edge of her bed. ULP-F then removed gloves and charted the medication administration on the MAR and hand sanitized. During observations on February 27, 2024, at 9:20 a.m., both ULP-E and ULP-F assisted R3 to the toilet. ULP-F went to the medication cabinet right outside the bathroom to set up R3's medications. ULP-F then placed the medication cup on the bathroom counter along with barrier cream and nystatin powder (anti-fungal). With gloves on, ULP-F applied lotion to R3's legs, applied compression socks to both legs, and put R3's shoes on. With same gloves, ULP-F applied barrier cream to R3's groin then nystatin powder to same area. With same gloves, ULP-F moved the wheelchair and touched the barrier cream and nystatin powder. ULP-F wiped R3's back end before applying barrier cream then pulled up R3's clean brief, pants and touched wheelchair. With same dirty gloves, ULP-F touched the wheelchair and gait belt to transfer R3 into the wheelchair. ULP-F then wheeled R3 to the sink and grabbed R3's medication cup for R3 to administer. ULP-F threw the medication cup away, removed gloves and put the barrier cream and nystatin powder back into the medicine cabinet, documented the medication administration on the eMAR, locked the cabinet with keys, put keys into her pockets then went into bathroom to comb R3's hair. ULP-F then grabbed R3's toothbrush and handed it to R3 and left the room. ULP-F then documented the cares on the iPad then shook	0 510			

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0 510	Continued From page 9 hands with R6 without any hand hygiene after performing cares to R3. On February 27, 2024, at 9:40 a.m., ULP-F stated she was trained to remove gloves after all cares were completed on one resident. ULP-F also stated she was trained to wash hands after removing gloves. ULP-F stated she did not remove gloves and perform hand hygiene after toileting and before medication administration. On February 27, 2024, 12:00 p.m., clinical nurse supervisor (CNS)-A stated staff were expected to remove gloves in between each task and perform hand hygiene. ULP-F's Toileting Assistance Competency dated August 11, 2023, indicated ULP-F was competent to remove gloves after toileting and perform hand hygiene before applying clean gloves before assisting resident off the toilet. Once resident was off toilet, ULP-F would wash hands. ULP-F's Hand Washing Competency dated August 11, 2023, indicated ULP-F was competent on hand washing and using alcohol-based hand sanitizer. The licensee's 5.02 Competency Training Evaluations policy dated June 1, 2022, indicated all ULP's would be trained and competent on basic infection control, including blood-borne pathogens and maintenance of a clean and safe environment. The licensee's 8.09 Hand Washing policy effective June 1, 2022, indicated when conducting a procedure requiring the use of gloves, proper hand hygiene should be completed before donning gloves and after removing gloves.	0 510			

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0 510	Continued From page 10 The Centers for Disease Control (CDC) Hand Hygiene in Health Care Settings Healthcare Providers dated January 30, 2020, directed health care workers to wash their hands immediately before touching a [resident], after touching a patient or patient's immediate environment, after glove removal, and when hands were visibly soiled. No further information was 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 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	0 650			

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(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
0 650	Continued From page 11 (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the employee record contained the required content for two of two employees (lead unlicensed personnel (L/ULP)-B, unlicensed personnel (ULP)-E). 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: L/ULP-B L/ULP-B was hired on May 15, 2023, to help with staff scheduling, compliance, and provide services to licensee's residents. Between February 26, 2024, and February 28, 2024, surveyor observed L/ULP-B assist with gathering employee and resident records for surveyor and interact with residents and ULPs throughout each day. L/ULP-B's Competencies Tracking Form (tracking tool only, not proof of completion of trainings) dated June 11, 2023, documented evidence of competencies but they were not signed by a registered nurse, it was for information purposes	0 650			

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0 650	Continued From page 12 only. L/ULP-B's training record lacked documentation of training and evidence of demonstrated competency on the following: -documentation requirements for all services provided; -maintenance of a clean and safe environment; -training on the prevention of falls for providers working with the elderly or individuals at risk of falls; -standby assistance techniques and how to perform them; -communication skills (competency only); -understanding appropriate boundaries between staff and residents (competency only); -procedures to utilize in handling various emergency situations (competency only); -awareness of commonly used health technology equipment and assistive devices (competency only); -basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes; -recognizing physical, emotional, cognitive, and developmental needs of the resident; -range of motioning, and positioning; and -oxygen therapy. On February 26, 2024, at 2:00 p.m., L/ULP-B stated she completed the "packet" when she started otherwise the training records from her previous job (unrelated licensee) were transferrable according to the licensee. ULP-E ULP-E was hired on January 2, 2024, to provide services to licensee's residents. On February 27, 2024, between 9:05 a.m., and	0 650			

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0 650	Continued From page 13 9:25 a.m., surveyor observed ULP-E administer medication, provide transfer, toileting and mobility assistance, and tidy rooms. ULP-E's training record lacked documentation of training and evidence of demonstrated competency on the following: -documentation requirements for all services provided; -maintenance of a clean and safe environment; -training on the prevention of falls for providers working with the elderly or individuals at risk of falls; -medication, exercise, and treatment reminders; -standby assistance techniques and how to perform them; -awareness of confidentiality and privacy; -understanding appropriate boundaries between staff and residents; -procedures to utilize in handling various emergency situations; -awareness of commonly used health technology equipment and assistive devices; -observation, reporting, and documentation of resident status; -basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes; -reading, and recording temperature, pulse, and respirations of the resident; -recognizing physical, emotional, cognitive, and developmental needs of the resident; -range of motioning, and positioning; and -oxygen therapy. ULP-E's training record included blank forms for return demonstrations to be completed between ULP-E and the registered nurse (RN) for oxygen therapy and vital signs (temperature, blood pressure, pulse, and respirations).	0 650			

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0 650	Continued From page 14 On February 27, 2024, at 11:33 a.m., ULP-E stated she was trained by L/ULP-B on oxygen therapy but did the oxygen competency packet with RN-C which they forgot to document. ULP-E stated she was trained by L/ULP-B how to perform vital signs on a resident after a fall. On February 28, 2024, at 1:55 p.m., RN-C recalled training ULP-E on vital signs, range of motion and positioning, and oxygen therapy but saw that the competency forms were blank in ULP-E's training record. RN-C stated there had been a lot of staff turnover, so it was hard to remember. On February 29, 2024, at 9:08 a.m., owner and licensed assisted living director (LALD)-D was informed about the missing training and competency testing content, and she stated she would look into utilizing Educare (online training program) for more training courses to ensure trainings are completed. The licensee's 4.05 Employee Records policy effective June 1, 2022, indicated employee records for each person would include records of all training and in-service education required and/or provided including record of competency testing as required. The licensee's 5.02 Competency Training Evaluations policy effective June 1, 2022, indicated a copy of all education, training, and competency testing on the above content shall be kept in each employee's personnel file. No further information provided. TIME PERIOD FOR CORRECTION:	0 650			

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0 650	Continued From page 15 Twenty-One (21) days	0 650			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all residents receiving services under the assisted living with dementia license. Additionally, the	0 680			

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0 680	Continued From page 16 licensee failed to post an emergency disaster plan prominently. 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: During facility tour on February 26, 2024, at 11:06 a.m., surveyor could not locate the EPP or a posting indicating where the EPP could be found. On February 26, 2024, at 12:54 p.m., surveyor asked clinical nurse supervisor (CNS)-A where the EPP was located, and CNS-A stated it was kept in the locked office. CNS-A was unaware the EPP needed to be accessible to the public. The licensee's Emergency Response, Reporting and Review Policy and Plan dated August 1, 2021, did not include the following required content: - communication plan must include all the following names/contact information: - entities providing services under agreement; - residents' physicians; and - volunteers. On February 29, 2024, at 11:05 a.m., co-owner (O)-H stated the emergency kit was scattered within the nursing office, and owner/licensed assisted living director (LALD)-D stated they needed to organize the kit for accessibility. O-H	0 680			

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0 680	Continued From page 17 thought the names/contact information pertained to contracted services for the licensee and O-H was unaware the EPP needed to be accessible to the public. The licensee's 9.01 Emergency Preparedness Plan-Appendix Z Compliance policy dated June 1, 2022, indicated the licensee would include all required components of appendix Z. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
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	0 810			

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0 810	Continued From page 18 their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to make the fire safety and evacuation plan readily available. 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 February 28, 2024, at 10:30 a.m., survey staff toured the facility with maintenance (M)-G. During the tour, survey staff observed the fire safety and evacuation plan was not located in a central location readily available at all times in the facility. On February 28, 2024, at 11:20 a.m., survey staff requested documents on the fire safety and	0 810			

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0 810	Continued From page 19 evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility from M-G. During an interview on February 28, 2024, at 11:40 a.m., M-G stated they did not know where the FSEP was located and suggested survey staff talk with lead unlicensed personnel (ULP)-B. On February 28, 2024, at 11:45 a.m., survey staff requested the FSEP from ULP-B. During an interview on February 28, 2024, at 12:35 p.m., ULP-B stated the FSEP had not been located and verified the FSEP was not readily available. On February 28, 2024, at 7:02 p.m., the licensee emailed the FSEP to survey staff. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
0 970 SS=C	144G.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 all licensee's residents.	0 970			

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0 970	Continued From page 20 This had the potential to affect all residents. 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: On February 28, 2024, at 9:00 a.m., licensee provided the surveyor with a blank contract and stated the same was used for all licensee's residents. The licensee's undated Assisted Living Contract contained a waiver language in the following section: - Section "Miscellaneous Provisions" read - one of the requirements of [resident's] stay is that [resident] must maintain at least \$100,000 of personal liability insurance. The [licensee] disclaims any and all responsibility for damages to [residents] personal property arising from fires and other events. [Resident] must name the [licensee] as "additional interest" on the policy, which would notify the [licensee] in the event of a lapse or cancellation. On February 29, 2024, at 9:08 a.m., co-owner (O)-H stated he was not aware there could not be a waiver of liability. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970			

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01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a registered nurse (RN) conducted direct supervision of staff performing a delegated task within 30 days of providing services for three of three employees (lead unlicensed personnel (L/ULP)-B, ULP-E, ULP-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	01440			

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01440	Continued From page 22 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: L/ULP-B L/ULP-B was hired on May 15, 2023, to help with staff scheduling, compliance and provide services to licensee's residents. L/ULP-B's training record included an online training transcript (Relias) which indicated L/ULP-B completed various trainings between September 7, 2016, through March 17, 2023, through a previous licensee unrelated to current licensee. L/ULP-B's Employee Orientation Checklist signed by L/ULP-B on January 23, 2024, but not signed by trainer, indicated L/ULP-B received some orientation training. Between February 26, 2024, and February 28, 2024, surveyor observed L/ULP-B assist with gathering employee and resident records for surveyor and also perform interactions with residents and ULP's throughout each day. ULP-E ULP-E was hired on January 2, 2024, to provide services to licensee's residents. ULP-E's training record included an online training transcript (Educare) which indicated ULP-E completed orientation training between January 21, 2024, through January 22, 2024.	01440			

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01440	Continued From page 23 On February 27, 2024, at 11:33 a.m., ULP-E stated she started working within the week of hire and worked full time hours. On February 27, 2024, between 9:05 a.m., and 9:25 a.m., surveyor observed ULP-E administer medication, provide transfer, toileting and mobility assistance, and tidy rooms. ULP-F ULP-F was hired on July 20, 2023, to provide services to licensee's residents. ULP-F's training record included orientation training completed on August 11, 2023, and September 9, 2023. On February 27, 2024, between 8:40 a.m., and 9:35 a.m., surveyor observed ULP-F provide medication administration to multiple residents, transfer assistance, mobility assistance, toileting assistance, and dressing and grooming. L/ULP-B, ULP-E, and ULP-F's employee records lacked evidence an RN supervision was conducted within 30 days of providing services. On February 28, 2024, at 12:37 p.m., clinical nurse supervisor (CNS)-A stated they did not perform supervision of staff performing delegated tasks within 30 days of providing services for anyone unless there were medication errors. The licensee's 6.17 Supervision of Staff-Delegated Services policy effective June 1, 2022, indicated direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual began working for [licensee] and first performs the delegated tasks for residents	01440			

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01440	Continued From page 24 and thereafter as needed based on performance. The policy also indicated it was the responsibility of the RN staff to ensure the supervision was done within the time frames outlined above and specified on the client's service plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440			
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and	01470			

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(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
01470	Continued From page 25 Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) 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 completed required orientation before providing services for three of three supervising and direct care employees (clinical nurse supervisor (CNS)-A, lead unlicensed personnel (L/ULP)-B, ULP-E). Additionally, licensee failed to ensure orientation training was completed prior to providing services for ULP-F.	01470			

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01470	Continued From page 26 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: MISSING ORIENTATION CNS-A CNS-A was hired on April 30, 2023, to provide direct cares to residents and oversight to ULPs. CNS-A's employee record included an Educare (online training platform) transcript which indicated CNS-A was trained on Assisted Living bill of rights on September 12, 2023. CNS-A's employee record lacked orientation to the following topics at the time of hire: -overview of Assisted Living statutes; -handling emergencies and using emergency services; -reporting maltreatment of vulnerable adults or minors; -handling of resident complaints, reporting of complaints, where to report; -consumer advocacy services; -review of types of Assisted Living services the employee will provide and provider's scope of license -principles of person-centered planning/service delivery; and -orientation to each specific resident and services provided.	01470			

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01470	Continued From page 27 CNS-A was observed providing cares and managing the licensee throughout the survey on February 26, 27, and 28, 2024. On February 26, 2024, at 3:30 p.m., CNS-A stated she began working on May 8, 2023, and the course she completed on Educare was not assigned to her until September 2023, and she could not assign herself or other staff additional courses because she didn't have the ability to do so, only the owner and licensed assisted living director (LALD)-D. L/ULP-B L/ULP-B was hired on May 15, 2023, to help with staff scheduling, compliance and provide services to licensee's residents. L/ULP-B's training record included an online training transcript (Relias) which indicated L/ULP-B completed various trainings between September 7, 2016, through March 17, 2023, through a previous licensee unrelated to current licensee. L/ULP-B's Employee Orientation Checklist signed by L/ULP-B on January 23, 2024, but not signed by trainer, indicated L/ULP-B received some orientation training. L/ULP-B's employee record lacked orientation to the following topics at the time of hire: -overview of Assisted Living statues; -consumer advocacy services; -review of types of Assisted Living services the employee will provide and provider's scope of license; and -principles of person-centered planning/service delivery.	01470			

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01470	Continued From page 28 Between February 26, 2024, and February 28, 2024, surveyor observed L/ULP-B assist with gathering employee and resident records for surveyor and interact with residents and ULPs throughout each day. On February 26, 2024, at 2:00 p.m., L/ULP-B stated she started working as a lead ULP the end of May or the beginning of June and the training she received was the packet containing training and competencies of delegated tasks. Surveyor asked L/ULP-B if she received orientation training, and L/ULP-B stated they were not completed because owner/licensed assisted living director (LALD)-D said they were transferrable from her previous job. ULP-E ULP-E was hired on January 2, 2024, to provide services to licensee's residents. ULP-E's training record included an online training transcript (Educare) which indicated ULP-E completed Assisted Living bill of rights training on January 21, 2024. On February 27, 2024, at 11:33 a.m., ULP-E stated she started working within the week of hire and worked full time hours. ULP-E stated she completed some orientation training but did not complete the Assisted Living statues on Educare, did not complete handling emergencies and using emergency services, reporting maltreatment of vulnerable adults or minors, and consumer advocacy services. ULP-E's employee record orientation to the following topics at the time of hire: -overview of Assisted Living statues; -handing of resident complaints, reporting of	01470			

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01470	Continued From page 29 complaints, where to report; -reporting maltreatment of vulnerable adults or minors; -consumer advocacy services; -review of types of Assisted Living services the employee will provide and provider's scope of license; and -principles of person-centered planning/service delivery. On February 27, 2024, between 9:05 a.m., and 9:25 a.m., surveyor observed ULP-E administer medication, provide transfer, toileting and mobility assistance, and tidy rooms. LATE ORIENTATION TRAINING ULP-F was hired on July 20, 2023, to provide services to licensee's residents. ULP-F's training record indicated the following were completed on September 9, 2023: -overview of Assisted Living statues; -handing of resident complaints, reporting of complaints, where to report; -review of provider's policies and procedures; -handing of resident complaints, reporting of complaints, where to report -reporting maltreatment of vulnerable adults or minors; -consumer advocacy services; -review of types of Assisted Living services the employee will provide and provider's scope of license; and -principles of person-centered planning/service delivery. On February 27, 2024, between 8:40 a.m., and 9:35 a.m., surveyor observed ULP-F provide medication administration to multiple residents, transfer assistance, mobility assistance, toileting	01470			

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01470	Continued From page 30 assistance, and dressing and grooming. On February 27, 2024, at 10:49 a.m., ULP-F stated she started training and shadowing other staff right away once hired. ULP-F stated orientation training was completed in September was probably because CNS-A was "busy." On February 27, 2024, at 12:00 p.m., L/ULP-B and CNS-A were both open to using Educare for training but said they did not have access to Educare to assign courses, and both agreed there was inconsistency on training records. On February 29, 2024, at 9:08 a.m., LALD-D stated going forward, they will ensure orientation training is completed on the first day of their training and would look into utilizing Educare to ensure compliance. The licensee's 4.18 Employee General Orientation effective June 1, 2022, indicated general orientation would be scheduled to begin immediately upon hire of all new employees and be completed within the specified time frame. The policy also indicated employees should not perform job duties before completion of orientation to the job including general and safety orientation. Lastly, the policy indicated an orientation checklist would be completed by the employee and trainer, signed by each person, and will be filed in the employee's record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470			

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01540	Continued From page 31	01540			
01540 SS=D	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of one employee (clinical nurse supervisor (CNS)-A) completed the required amount of dementia care training in the required time frame. 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).	01540			

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01540	Continued From page 32 The findings include: CNS-A was hired on April 30, 2023, to provide direct cares to residents and oversite to ULPs. CNS-A's employee record contained evidence of 9.25 hours of dementia care completed on September 12, and 14, 2023. CNS-A's employee record lacked evidence of required dementia training completed within 80 hours of start date. During entrance conference on February 26, 2024, at 10:00 a.m., CNS-A stated she worked Sundays, Tuesdays, flex Wednesdays, and Fridays. CNS-A was observed providing redirection and reassurance to residents with dementia as situations came up throughout the survey on February 26, 27, and 28, 2024. On February 26, 2024, at 3:30 p.m., CNS-A stated she began working on May 8, 2023, and the courses she completed on an online Educare program was not assigned to her until September 2023, and she could not assign herself or other staff additional courses because she didn't have the ability to do so, only the owner and licensed assisted living director (LALD)-D. The licensee's 5.03 Dementia Training policy effective June 1, 2022, indicated supervisors of direct care staff would complete eight (8) hours of initial training within 120 hours of the employment start date. The policy also indicated direct care employees would complete eight (8) hours of initial training within 80 hours of the employment start date.	01540			

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01540	Continued From page 33 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01540			
01620 SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days 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 complete a change in condition assessment after multiple falls and	01620			

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01620	Continued From page 34 upon hospice (end of life) admission for one of one resident (R6), and change in transfer assistance for one of one resident (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a 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: R6 R6's diagnoses included muscle weakness, repeated falls, Alzheimer's disease, and malnutrition. On February 26, 27, and 28, 2024, at various times, surveyor observed R6 sitting in a Broda chair (oversized reclining chair) out in the dining room visiting with multiple family members. R6's progress notes dated February 6, 2024, at 12:34 p.m., noted by clinical nurse supervisor (CNS)-A care conference was conducted in person with licensee and family regarding R6's recent decline in cognition and physical capabilities and hospice evaluation was suggested, which family agreed. R6's progress notes dated February 11, 2024, at 1:18 p.m., noted by CNS-A that resident fell that morning at 4:55 a.m., sustaining a skin tear to left elbow. R6's progress notes dated February 14, 2024, at	01620			

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01620	Continued From page 35 9:12 p.m., noted by CNS-A that resident's family had consulted with hospice at 10:00 a.m. that morning and was signed on to services and comfort medications were ordered by R6's medical provider. R6's progress notes dated February 15, 2024, at 7:55 p.m., noted by CNS-A it was reported R6 fell in the dining room. R6's progress notes dated February 20, 2024, at 9:52 p.m., noted by CNS-A that R6 fell at 7:30 p.m., attempting to self-transfer from bed to wheelchair and hit back of head per video footage. R6's progress notes dated February 21, 2024, at 8:32 p.m., noted by CNS-A that R6 fell out of her wheelchair in the dining room at 7:05 p.m. R6's [Licensee] Master Assessment dated December 16, 2023, was the most recent nursing assessment completed indicated R6 was physical assist of one for transfers, ambulation using a walker, dressing, and grooming. The assessment also indicated "N/A; no outside agencies" when asked if resident received care from an outside agency. R6's Service Plan Agreement signed February 6, 2024, indicated R6 received assistance with safety checks, ambulation with walker, hearing aids, medication set up and administration, showers, toileting, and personal cares. On February 28, 2024, at 2:09 p.m., CNS-A stated a change in condition assessment would be completed when a resident returns from the hospital or when a resident transitions to hospice care. Surveyor asked if an assessment was	01620			

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01620	Continued From page 36 completed for R6 when admitted to hospice, both CNS-A and registered nurse (RN)-C both agreed an assessment should have been completed. R3 R3's diagnoses included type 2 diabetes mellitus, peripheral vascular disease, and ataxia (lack of voluntary muscle movement). During observation on February 27, 2024, at 9:20 a.m., surveyor observed unlicensed personnel (ULP)-E and ULP-F perform a two-person transfer assist getting R3 out of bed utilizing a transfer belt (goes around resident's waist) and a floor to ceiling transfer pole. During the same observation, toileting, compression sock application, grooming and medication administration were observed between ULP-E and ULP-F. R3's Service Plan Agreement signed October 5, 2023, indicated R3 received assistance with safety checks, bathing, housekeeping, laundry, medication set up and administration, hearing aids, transfer assist of one staff, dressing, and grooming. R3's [Licensee] Master Assessment dated February 21, 2024, CNS-A assessed R3 required physical assist of one staff for transfers getting in and out of bed. On February 28, 2024, at 10:25 a.m., registered nurse (RN)-C stated R3 was a two-person assist with transfers out of bed. On February 28, 2024, at 2:55 p.m., CNS-A stated she completed majority of the 90-day assessments. CNS-A completed assessments based on day-to-day observations. CNS-A also	01620			

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01620	Continued From page 37 reviewed resident progress notes, staff communication logs, reviewed fall and medication incident reports, and interviewed staff during their monthly meetings. If residents were working with physical therapy (PT) or occupational therapy (OT), CNS-A would check with them regarding resident status. CNS-A stated R3 was requiring assist of three staff so they started utilizing the sit to stand transfer device, which R3 hated using so PT/OT recommended the use of a floor to ceiling transfer pole to assist with transfers in and out of bed. CNS-A stated R3 was now requiring assist of two staff using the transfer pole. On February 28, 2024, at 3:02 p.m., ULP-I stated R3 was two-person assist with transfers in and out of bed. The licensee's 6.01 Assessments, Reviews & Monitoring policy effective October 14, 2022, indicated resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620			
01640 SS=E	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	01640			

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01640	Continued From page 38 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 two of two resident's (R2, R3) service plan were revised to include current transfer assistance requirements. 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 R2's diagnoses included type 2 diabetes mellitus, acute respiratory failure with hypoxia (lack of oxygen), malnutrition, and muscle weakness.	01640			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39714	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/29/2024
NAME OF PROVIDER OR SUPPLIER ATLAS VILLAS MEMORY CARE			STREET ADDRESS, CITY, STATE, ZIP CODE ATLAS VILLAS MEMORY CARE CENTERVILLE, MN 55038		
(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
01640	Continued From page 39 During observation on February 27, 2024, at approximately 9:10 a.m., unlicensed personnel (ULP)-E set up and administered a medication via nebulizer (mist inhaled into lungs) while R2 was lying in bed. R2's Level of Care Assessment dated January 22, 2024, assessed R2 required assist of one person for transfers. R2's Service Plan Agreement signed on January 8, 2024, indicated R2 received assistance with safety checks, oxygen therapy, toileting, escort to meals, medication set up and administration, and dressing and grooming. The service plan lack instruction for transfer assistance. R3 R3's diagnoses included type 2 diabetes mellitus, peripheral vascular disease, and ataxia (lack of voluntary muscle movement). During observation on February 27, 2024, at 9:20 a.m., surveyor observed unlicensed personnel (ULP)-E and ULP-F perform a two-person transfer assist getting R3 out of bed utilizing a transfer belt (goes around residents' waist) and a floor to ceiling transfer pole. During the same observation, toileting, compression stocking application to both lower legs, grooming and medication administration were observed between ULP-E and ULP-F. R3's Service Plan Agreement signed October 5, 2023, indicated R3 received assistance with safety checks, transfer assist with one staff person, bathing, housekeeping, laundry, medication set up and administration, hearing aids, and dressing and grooming.	01640			

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01640	Continued From page 40 On R3's Level of Care Assessment dated February 21, 2024, CNS-A assessed R3 required physical assist with one staff person for transfers getting in and out of bed. On February 28, 2024, at 10:25 a.m., registered nurse (RN)-C stated R3 was a two-person assist with transfers out of bed. On February 28, 2024, at 2:55 p.m., clinical nurse supervisor (CNS)-A stated R3 was requiring assist of three staff so they started utilizing the sit to stand transfer device, which R3 hated using so PT/OT recommended the use of a floor to ceiling transfer pole to assist with transfers in and out of bed. CNS-A stated R3 was now requiring assist of two staff using the transfer pole. On February 28, 2024, at 3:02 p.m., ULP-I stated R3 was two-person assist with transfers in and out of bed. On February 28, 2024, at 3:10 p.m., CNS-A agreed R2 and R3's service plans did not include current transfer assistance each resident required. The licensee's 2.38 Resident Record-Information and Content policy effective June 1, 2022, indicated the record would include licensee's current and previous assessments and service plans and documentation that services have been provided as identified in the service plan. No further information provided. TIME PERIOD TO CORRECT- Twenty-one (21) days	01640			

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01650	Continued From page 41	01650			
01650 SS=E	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 observation, interview, and record review, the licensee failed to ensure the resident service plan included the required content for two of two residents (R2, R3).	01650			

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01650	Continued From page 42 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 R2's diagnoses included type 2 diabetes mellitus, acute respiratory failure with hypoxia (lack of oxygen), malnutrition, and muscle weakness. R2's Service Plan Agreement signed on January 8, 2024, indicated R2 received assistance with safety checks, oxygen therapy, toileting, escort to meals, medication set up and administration, and dressing and grooming. R2's Attachment D Service Plan signed June 13, 2023, listed the service fee, schedule and methods of monitoring assessments of resident, and a contingency plan. During observation on February 27, 2024, at approximately 9:10 a.m., unlicensed personnel (ULP)-E set up and administered a medication via nebulizer while R2 was lying in bed. R3 R3's diagnoses included type 2 diabetes mellitus, peripheral vascular disease, and ataxia (lack of voluntary muscle movement). R3's Service Plan Agreement signed October 5, 2023, indicated R3 received assistance with	01650			

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01650	Continued From page 43 safety checks, bathing, housekeeping, laundry, medication set up and administration, hearing aids, and dressing and grooming. R3's Attachment D Service Plan signed June 13, 2023, listed the service fee, schedule and methods of monitoring assessments of resident, and a contingency plan. During observation on February 27, 2024, at 9:20 a.m., surveyor observed ULP-E and ULP-F perform a two-person transfer assist getting R3 out of bed utilizing a transfer belt (goes around residents' waist) and a floor to ceiling transfer pole. During the same observation, toileting, compression sock application, grooming and medication administration were observed between ULP-E and ULP-F. R2 and R3's service agreements lacked the following content on their service plans: -the schedule and methods of monitoring staff providing services. During interview on February 29, 2024, at 9:08 a.m., owner/licensed assisted living director (LALD)-D and co-owner (O)-H both stated the service plan did not include a schedule and method of monitoring staff. The licensee's 6.08 Service Plan policy dated October 14, 2022, indicated the service plan must include: -description of services that are to be provided based on the most recent assessment and resident preferences; -fees for services to be provided; -the frequency of each service to be provided based on the most recent assessment and resident preferences;	01650			

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01650	Continued From page 44 -an identification of the type staff or categories that will provide the services; -a schedule and method for the next planned assessment or monitoring; -a schedule and method for the next planned monitoring of staff providing services; -a contingency plan that includes: a. actions [licensee] will take if scheduled service cannot be provided; b. information regarding how the resident can contact [licensee]; c. identification and contact information of who the resident has authorized, if any, to sign for the resident in an emergency; and d. how the facility will support documented resident health care directive decisions, if any-including circumstances in which emergency medical services are not to be summoned. The licensee's 6.17 Supervision of Staff-Delegated Services policy effective June 1, 2022, indicated direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual began working for [licensee] and first performs the delegated tasks for residents and thereafter as needed based on performance. The policy also indicated it was the responsibility of the registered nurse staff to ensure the supervision was done within the time frames outlined above and specified on the client's service plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650			

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01770	Continued From page 45	01770			
01770 SS=F	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure documentation of medication setup included all the required content for three of three residents (R4, R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on February 26, 2024, at 10:00 a.m., clinical nurse supervisor (CNS)-A stated the nurses set up medications for all residents by filling two medication strips for each person and they were stored in a locked cabinet within each residents' room. R4 During observation on February 27, 2024, at 8:40 a.m., unlicensed personnel (ULP)-F entered R4's room to retrieve numbing throat spray and cough	01770			

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01770	Continued From page 46 drops. Surveyor observed medication strips located within the cabinet. ULP-F administered medication to R4 then documented the administration in the electronic medication administration record (eMAR). R4's diagnoses included dementia, chronic gout (inflammation of joints due to excess uric acid), and chronic kidney disease. R4's Service Plan Agreement dated September 1, 2023, indicated R4's services included medication administration from medication dispenser. R2 During observation on February 27, 2024, at 9:10 a.m., ULP-E entered R2's room retrieve medication for a nebulizer from R2's cabinet. Surveyor observed medication strips within the cabinet. ULP-E placed the nebulizer mask on R2's face while R2 was lying in bed. R2's diagnoses included type 2 diabetes, acute respiratory failure, and muscle weakness. R2's Service Plan Agreement dated January 8, 2024, indicated R2's services included medication set up by the registered nurse (RN) and administration by the ULPs. R3 During observation on February 27, 2024, at 9:20 a.m., before morning cares, ULP-E dispensed medications from the medication strip into a plastic medication cup and placed them on the bathroom counter. Then at approximately 9:30 a.m., after a transfer out of bed, toileting, dressing, and grooming, ULP-E gave the medication cup to R3 to administer medications	01770			

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01770	Continued From page 47 then documented in the eMAR. R3's diagnoses included type 2 diabetes mellitus, peripheral vascular disease, and ataxia (lack of voluntary muscle movement). R3's Service Plan Agreement dated October 5, 2023, indicated R3's services included medication set up by the RN and administration by the ULPs. R4, R2, and R3's medical record lacked required medication set up documentation by the nurse to include the following: -name of medication; -quantity of dose; -times to be administered; and -route of administration. A document titled Weekly Medication Minder Pre-Pour Log dated February 20, 2024, through February 26, 2024, included resident names, nurse signature, and the following note "complete" for each resident. On February 28, 2024, at 2:18 a.m., CNS-A provided the above document and asked surveyor if she was documenting it correctly. CNS-A stated she did this documentation for all residents. CNS-A stated she would start documenting on each resident's MAR. The licensee's 7.09 Medication Management-Dosage Box Setup policy effective June 1, 2022, indicated when a licensed nurse has completed setting up medications into the dosage box, the set-up is documented on the MAR. No further information was provided.	01770			

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01770	Continued From page 48	01770			
	TIME PERIOD FOR CORRECTION: Seven (7) days				
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 treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced	01940			

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01940	Continued From page 49 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, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a 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 R2's diagnoses included type 2 diabetes mellitus, acute respiratory failure with hypoxia (lack of oxygen), malnutrition, and muscle weakness. During observation and interview on February 27, 2024, at approximately 9:10 a.m., unlicensed personnel (ULP)-E set up and administered a medication via nebulizer (mist inhaled into lungs) while R2 was lying in bed. Surveyor observed two oxygen (O2) concentrators (device takes room air and filters it, giving more O2) within the R2's room. Surveyor asked when R2 utilized the O2. ULP-E stated R2 would let staff know if she needed O2 but if R2's O2 level (checked using an oximeter on a finger) was below 96% (for most people, a healthy blood O2 level is 95-100%), ULP-E would give her oxygen. ULP-E stated the O2 flow rate was already set when she turned the O2 concentrator on, but she wasn't sure how much O2 R2 was supposed to receive. ULP-E stated the flow rate should be on the electronic	01940			

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01940	Continued From page 50 medication administration record (eMAR). R2's [Licensee] Master Assessment dated January 22, 2024, assessed R2 required assistance with O2 therapy on an as needed basis (PRN) and required assistance with checking blood O2 levels using an oximeter. R2's Service Plan Agreement signed on January 8, 2024, indicated R2 received assistance with O2 therapy. The service plan instructed ULP's to check O2 levels four times a day and administer PRN O2 if O2 levels were below 90%. R3's provider orders dated December 14, 2023, ordered to discontinue (DC) supplemental O2 and start supplemental O2 via nasal cannula (tube that carries O2 to nostrils) at 2-6L (O2 flow rate) PRN (as needed) for SOB (shortness of breath) to keep O2 sat (saturation) at or above 90%." R2's medical record included a description dated December 15, 2023, indicating the following "1) DC scheduled supplemental O2. 2) supplemental oxygen via NC (nasal cannula) at 2-6L PRN for SOB to keep O2 sat at or above 90%." On February 28, 2024, at 10:46 a.m., surveyor asked lead unlicensed personnel (ULP)-B how much O2 to administer if O2 level was below 90%, and she stated she would call the on-call nurse. ULP-B would document the O2 administration under the O2 service and indicate when and how much was administered. There was no instruction in the medical record indicating when to remove O2 from R2. On February 28, 2024, at 12:20 p.m., clinical nurse supervisor (CNS)-A stated there used to be instruction for ULPs to contact the nurse if R2's	01940			

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01940	Continued From page 51 O2 saturation level was below 90%. CNS-A stated there was no instruction on when to remove the O2. R3's record lacked a treatment therapy management plan to include the following content: -documentation of specific resident instructions relating to the treatment or therapy administration; -procedures for notifying a nurse or appropriate licensed health professional when a problem arises with the treatments or therapy services; and -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. R3 R3's diagnoses included type 2 diabetes mellitus, peripheral vascular disease, and ataxia (lack of voluntary muscle movement). During observation on February 27, 2024, at 9:20 a.m., surveyor observed unlicensed personnel (ULP)-F apply compression stockings to both R3's lower legs during morning cares. On R3's [Licensee] Master Assessment dated February 21, 2024, under "Functional Capabilities," it was indicated not applicable regarding R3 requiring assistance with compression stockings. R3's prescriber order dated September 14, 2023, ordered compression stocking to be applied in the morning and removed at night.	01940			

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01940	Continued From page 52 R3's Service Plan Agreement signed October 5, 2023, indicated R3 received assistance with safety checks, transfer assist with one staff person, bathing, housekeeping, laundry, medication set up and administration, hearing aids, and dressing and grooming. The service plan lacked a written statement that compression stockings would be provided to the resident. The licensee's 7.05 Treatment & Therapy Management Plan effective June 1, 2022, indicated the current individualized treatment and therapy management record for each resident must contain the following: -a statement of the type of service that will be provided; -documentation of specific resident instructions relating to the treatments or therapy administration; -identification of treatment or therapy tasks that will be delegated to ULP; -procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; -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 licensee's 7.15 Medication & Treatment-Administration & Delegation policy effective June 1, 2022, prior to an ULP delegation, the licensee would prepare and include in the service plan a written statement of the treatment service that would be provided to the resident.	01940			

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01940	Continued From page 53 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940			
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on 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 for the facility. This deficient practice had the ability to 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	02040			

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02040	Continued From page 54 of the residents). Findings include: On February 28, 2024, at 11:20 a.m., survey staff requested documents on a safety risk or hazard vulnerability assessment of the physical environment for facilities with a secured dementia care unit from maintenance (M)-G. During an interview on February 28, 2024, at 11:40 a.m., M-G stated they did not know where this assessment was located and suggested survey staff talk with lead unlicensed personnel (ULP)-B. On February 28, 2024, at 11:45 a.m., survey staff requested the safety risk or hazard vulnerability assessment of the physical environment from ULP-B. Record review of the available documentation indicated the licensee had completed a hazard and vulnerability assessment tool that identified human, property, and business hazards. Mitigation of identified hazards was not included. During an interview on February 28, 2024, at 12:35 p.m., ULP-B verified mitigation factors for physical environment hazards were not included. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040			
02110 SS=F	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's	02110			

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02110	Continued From page 55 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. (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, licensee failed to develop policies and procedures required in the licensing of assisted living facilities with dementia care were developed for each resident and/or the residents legal/designated representative at the time of move-in. This had the potential to affect all residents.	02110			

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02110	Continued From page 56 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee lacked evidence the required policies and procedures related to dementia care were provided to each resident and/or the resident's legal and designated representative. The licensee held a Provisional Assisted Living with Dementia Care license through February 27, 2024, and was licensed for a bed capacity of 20 residents. The licensee lacked the following policies under 144G.82, Subd.3: -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; -evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; -wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; -medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; -staff training specific to dementia care;	02110			

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02110	Continued From page 57 -description of life enrichment programs and how activities are implemented; -description of family support programs and efforts to keep the family engaged; -limiting the use of public address and intercom systems for emergencies and evacuation drills only; -transportation coordination and assistance to and from outside medical appointments; and -safekeeping of residents' possessions. In addition, the licensee lacked evidence to verify the required dementia care policies and procedures had been developed and provided to each resident and/or representative. On February 29, 2024, at 9:08 a.m., owner/licensed assisted living director (LALD)-D and co-owner (O)-H stated they were unaware of the required policies and procedures. The licensee's 2.38 Resident Record-Information and Content policy effective June 1, 2022, indicated the resident record must include other documentation required under this chapter and relevant to the resident's services or status. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02110			
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.	02310			

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02310	Continued From page 58 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 of one resident (R6) who utilized consumer bed rails, resulting in an immediate order. In addition, the licensee failed to complete re-assessment and measurements resulting in an order that was not immediate for four of four residents (R2, R3, R4, R5). 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 February 26, 2024, at 10:00 a.m., during entrance conference, licensee provided a current client roster dated February 22, 2024. The client roster had a check mark "X" indicating R5 had "bed rails or restraints." IMMEDIATE ORDER On February 27, 2024, at 1:51 p.m., clinical nurse supervisor (CNS)-A was made aware R6 had two round Halo bed rails (one on each side) by observing the bed on a video monitor screen while in the office. CNS-A stated R6 did not have bed rails before, and staff did not inform her that they arrived. Unlicensed personnel (ULP)-B	02310			

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02310	Continued From page 59 stated the bed with bed rails arrived on Friday, February 23, 2024, at the end of his/her shift. During observation and interview on February 27, 2024, at 2:00 p.m., surveyor and ULP-F entered R6's room and observed two round shaped Halo bed rails (one on each side near the head of the bed). ULP-F stated R6 received the new bed with Halo bed rails three or four days ago. ULP-F was unsure if the on-call registered nurse (RN) was notified of the new bed. R6 was admitted to licensee on August 3, 2023, and began receiving hospice (end of life) services on February 14, 2024. R6's Service Plan Agreement dated February 6, 2024, indicated R6 required safety checks, assistance with dressing, grooming, toileting, escorts to dining room, medication administration, showers, laundry, and housekeeping. R6's [licensee] Master Assessment dated December 16, 2023, lacked a bed rail assessment. R6's Progress Notes dated February 21, 2024, at 12:57 p.m., noted that RN-C discussed the benefits of a hospital bed for ease of cares and safety. RN-C also noted a hospital bed, air mattress, one Halo side rail ordered for delivery on Friday after 3:00 p.m., and that family was in agreement with plan. R6's record lacked the following: -ongoing assessment for the use of an assistive device as required in the uniform assessment tool -documentation of installation and use of the device according to manufacturer's guidelines; -evidence the licensee referred to the Consumer	02310			

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02310	Continued From page 60 Product Safety Commission (CSPC) for bed rail recall information; and -documentation of a risk vs. benefits discussion (individualized to the resident's risks). NON-IMMEDIATE ORDER/CONSUMER SIDE RAIL R2 R2's diagnoses included dementia, type two diabetes mellitus, acute respiratory failure with hypoxia (lack of oxygen), malnutrition, and muscle weakness. During observation on February 27, 2024, at approximately 9:10 a.m., ULP-E set up and administered a medication via nebulizer (mist inhaled into lungs) while R2 was lying in bed. Surveyor observed two Halo side rails on a high/low hospital bed. Halos were secured to bed frame. R2's Service Plan Agreement signed on January 8, 2024, indicated R2 received assistance with safety checks, oxygen therapy, toileting, escort to meals, medication set up and administration, and dressing and grooming. R2's Level of Care Assessment dated January 22, 2024, assessed R2 required assist of one person for transfers. R2's [Licensee] Master Assessment dated January 22, 2024, assessed R2 to be high risk for falls due to dementia, decreased vision, recent falls, incontinence of bowel and bladder, and confusion. R2's Side Rail Use Assessment Form dated January 22, 2024, indicated R2 had bilateral (two) side rails to promote independence. The	02310			

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02310	Continued From page 61 assessment indicated resident and resident's responsible party have been notified of the risks involved with side rail use. R2's record lacked the following: -condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; -documentation of installation and use of the device according to manufacturer's guidelines; -physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and -evidence the licensee referred to the Consumer Product Safety Commission (CSPC) for bed rail recall information. R3 R3's diagnoses included dementia, type 2 diabetes mellitus, peripheral vascular disease, and ataxia (lack of voluntary muscle movement). During observation on February 27, 2024, at 9:20 a.m., surveyor observed ULP-E and ULP-F perform a two-person transfer assist getting R3 out of bed utilizing a transfer belt (goes around residents' waist) and a floor to ceiling transfer pole. R3 had one Halo side rail on the right side of a high/low hospital bed. Halo was secured to bed frame. During the same observation, toileting, compression stocking application to both lower legs, grooming and medication administration were observed between ULP-E and ULP-F. R3's Service Plan Agreement signed October 5, 2023, indicated R3 received assistance with safety checks, transfer assist with one staff person, bathing, housekeeping, laundry, medication set up and administration, hearing	02310			

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02310	Continued From page 62 aids, and dressing and grooming. On R3's Level of Care Assessment dated February 21, 2024, CNS-A assessed R3 required physical assist with one staff person for transfers getting in and out of bed. R3's [Licensee] Master Assessment dated February 21, 2024, assessed R3 to be high risk for falls due to dementia, recent falls, arthritis, incontinence of bladder. R3's Side Rail Use Assessment Form dated July 13, 2023, indicated R3 had a side rail on the bed, served as an enabler to promote independence, and resident and resident's responsible party were notified of risks involved with side rail use. R3's record lacked the following: -assessment with each 90-day assessment and change of condition; -condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; -documentation of installation and use of the device according to manufacturer's guidelines; -physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and -evidence the licensee referred to the CSPC for bed rail recall information. R4 R4's diagnoses included repeated falls, spinal stenosis (narrowing of spine), hearing loss, and chronic obstructive pulmonary disease (COPD). On February 27, 2024, at 8:40 a.m., surveyor observed ULP-F administer medication to R4 while in dining room and place medications back	02310			

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02310	Continued From page 63 into R4's cabinet within apartment. Surveyor observed one Halo on right side of R4's regular bed. Halo was secured to bedframe. R4's Service Plan Agreement signed September 1, 2023, indicated R4 received assistance with safety checks, ambulation assist with two staff, bathing, housekeeping, laundry, compression stocking application/removal, medication set up and administration, hearing aids, and dressing and grooming. On R4's Level of Care Assessment dated December 16, 2023, assessed R4 required assistance with transfers and bed mobility. R4's [Licensee] Master Assessment dated December 16, 2023, assessed R4 to be high risk for falls due to decreased hearing/vision and wheelchair use. R4's Side Rail Use Assessment Form dated September 27, 2023, indicated R4 had a side rail on right side, served as an enabler to promote independence, risks vs benefits were reviewed with R4's responsible party. R4's record lacked the following: -assessment with each 90-day assessment and change of condition; -condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; -documentation of installation and use of the device according to manufacturer's guidelines; -physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and -evidence the licensee referred to the CSPC for bed rail recall information.	02310			

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02310	Continued From page 64 The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently Asked Questions (FAQs), last updated February 20, 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". Additionally, the MDH website indicated for "consumer beds", the licensees should refer to individual manufacturer's guidelines for appropriate installation, maintenance, and use. In addition, licensees should refer to the CSPC for the most up-to-date information related to	02310			

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02310	Continued From page 65 portable bed side rail recall information. The Halo Safety Ring Instructions obtained from "The Comfort Company" website on February 27, 2024, indicated "serious injury or death can result if the Halo Safety Ring is not properly installed." The instructions also indicated entrapment may occur and proper patient assessment and monitoring, and proper maintenance and use of equipment is required to reduce the risk of entrapment. NON-IMMEDIATE ORDER/HOSPITAL SIDE RAIL R5 R5's diagnoses included dementia, chronic kidney disease, moderate protein-calorie malnutrition, and abnormal weight loss. On February 27, 2024, at 10:03 a.m., surveyor observed R5's hospital bed (CHG Hospital Beds-Spirit Select Model 5700) which had four side rails, but upper two were raised. R5's Service Plan Agreement signed November 24, 2023, indicated R5 received assistance with safety checks, medication management, hearing aids, laundry, showers, transfers, morning and bedtime cares, and housekeeping. R5's [Licensee] Master Assessment dated December 16, 2023, assessed R5 required assistance physical assist of one staff for getting in and out of bed and using side rail for bed mobility. The assessment also indicated R5 was high risk for falls due to recent falls, decreased hearing, dementia, confusion, and incontinence of bladder.	02310			

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02310	Continued From page 66 R5's Side Rail Use Assessment Form dated May 23, 2023, indicated R5 had bilateral side rails and were used to promote independence. The assessment indicated the side rails were a permanent fixture, side rails did not have any spaces and met the regulation standards, and risks and benefits had been discussed with the resident and resident's responsible party. R5's record lacked the following: -assessment with each 90-day assessment and change of condition; and -side rail measurements. On February 27, 2024, between 12:33 and 12:45 p.m., CNS-A stated during side rail assessments, she determined the need for each resident, made sure the side rail was not a restraint, and said they only allowed the Halo side rails. CNS-A stated she will check with the resident to see if they are using the side rail(s) which they mostly use it for bed mobility. CNS-A stated she did not have Halo installation instructions available but said they usually come with it. CNS-A stated she was not sure who was responsible for making sure the side rails were installed correctly and was not aware of the requirement for recalls. CNS-A was not aware side rail assessments needed to be completed every 90-days or with a change in condition and measuring entrapment zones on hospital bed side rails. The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) dated February 20, 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	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39714	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/29/2024
NAME OF PROVIDER OR SUPPLIER ATLAS VILLAS MEMORY CARE			STREET ADDRESS, CITY, STATE, ZIP CODE ATLAS VILLAS MEMORY CARE CENTERVILLE, MN 55038		
(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
02310	Continued From page 67 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." "Additionally, the licensee must ensure the bed rail measurements are documented and that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendations." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Measurements; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - 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". Additionally, the MDH website indicated for hospital-style bed rails, the licensee must include in their documentation, the bed rail measurements and that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendations. The licensee's 1.11 Siderails policy effective June 1, 2022, indicated all staff should be watchful and report new side rail devices to the registered nurse immediately. The policy also indicated the licensee was responsible to assess the resident's cognitive and physical abilities, including their ability to call for help if entrapment occurs, assess	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39714	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/29/2024
NAME OF PROVIDER OR SUPPLIER ATLAS VILLAS MEMORY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE ATLAS VILLAS MEMORY CARE CENTERVILLE, MN 55038			
(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
02310	Continued From page 68 compliance with and maintain the side rails, according to manufacturer's instructions, and educate the resident and/or representatives on the risks of entrapment, including injury and death. The Food and Drug Administration's (FDA), 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, 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." No further information was provided. TIME PERIOD FOR CORRECTION: Immediate On February 28, 2024, the immediacy of the order was removed based on supervisory review. Noncompliance remains and the scope and level remain unchanged.	02310			

Type: Full
Date: 02/26/24
Time: 11:00:15
Report: 1029241061

Food and Beverage Establishment Inspection Report

Page 1

Location:

Atlas Villas Memory Care
1825 Main Street
Centerville, MN55038
Anoka County, 02

Establishment Info:

ID #: NHFID 3
Risk:
Announced Inspection: Yes

License Categories:

,
Expires on: / /

Operator:

Phone #:
ID #: 39714

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

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

hot water: = at 172 Degrees Fahrenheit
Location: dishwasher
Violation Issued: No

quaternary ammonium: = 200 ppm at Degrees Fahrenheit
Location: sanitizer bucket
Violation Issued: No

Food and Equipment Temperatures

Process/Item: milk
Temperature: 37 Degrees Fahrenheit - Location: 2-door upright
Violation Issued: No

Process/Item: shredded cheese
Temperature: 40 Degrees Fahrenheit - Location: under counter cooler
Violation Issued: No

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

Inspection conducted with Bethany Johnson, Executive Chef and Person-in-Charge.

Topics discussed included:

- receiving and cold holding temperatures
- cooking, and hot holding times and temperatures
- cooling times and temperatures
- equipment standards and maintenance

Type: Full
Date: 02/26/24
Time: 11:00:15
Report: 1029241061
Atlas Villas Memory Care

Food and Beverage Establishment Inspection Report

Page 2

- chemical and heat sanitizing
- employee hygiene and illness exclusion procedures
- barehand contact with ready to eat foods and glove/utensil use
- common reportable foodborne illness pathogens
- demonstration and dissemination of food safety knowledge
- recognizing and discarding contaminated foods

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 1029241061 of 02/26/24.

Certified Food Protection Manager Bethany A. Johnson

Certification Number: FM80003 Expires: 08/13/27

Inspection report reviewed with person in charge and emailed.

Signed: _____

Bethany Johnson
Executive Chef

Signed: 

Trevor McCliment
Public Health Sanitarian
Metro District Office
651-201-3957
trevor.mccliment@state.mn.us

Report #: 1029241061

DEPARTMENT OF HEALTH

Minnesota Department of Health
Food, Pools, and Lodging Services
625 Robert Street North
St. Paul

No. of RF/PHI Categories Out

0

Date

02/26/24

No. of Repeat RF/PHI Categories Out

0

Time In

11:00:15

Legal Authority MN Rules Chapter 4626

Time Out

Atlas Villas Memory Care

Address

1825 Main Street

City/State

Centerville, MN

Zip Code

55038

Telephone

License/Permit #

NHFID 3

Permit Holder

Purpose of Inspection

Full

Est Type

Risk Category

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item

Mark "X" in appropriate box for COS and/or R

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

Compliance Status

COS

R

Surpervision

1

IN

OUTPIC knowledgeable; duties & oversight

2

IN

OUTN/ACertified food protection manager, duties

Employee Health

3

IN

OUTMgmt/Staff;knowledge,responsibilities&reporting

4

IN

OUTProper use of reporting, restriction & exclusion

5

IN

OUTProcedures for responding to vomiting & diarrheal events

Good Hygenic Practices

6

IN

OUT

N/O

Proper eating, tasting, drinking, or tobacco use

7

IN

OUTN/ONo discharge from eyes, nose, & mouth

Preventing Contamination by Hands

8

IN

OUTN/OHands clean & properly washed

9

IN

OUTN/AN/ONo bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed

10

IN

OUTAdequate handwashing sinks supplied/accessible

Approved Source

11

IN

OUTFood obtained from approved source

12

IN

OUTN/AN/OFood received at proper temperature

13

IN

OUTFood in good condition, safe, & unadulterated

14

IN

OUT

N/A

N/OREquired records available; shellstock tags, parasite destruction

Protection from Contamination

15

IN

OUTN/AN/OFood separated and protected

16

IN

OUTN/AFood contact surfaces: cleaned & sanitized

17

IN

OUTProper disposition of returned, previously served, reconditioned, & unsafe food

Compliance Status

COS

R

Time/Temperature Control for Safety

18

IN

OUTN/ADiv>

N/O

Proper cooking time & temperature

19

IN

OUTN/ADiv>

N/O

Proper reheating procedures for hot holding

20

IN

OUTN/ADiv>

N/O

Proper cooling time & temperature

21

IN

OUTN/ADiv>

N/O

Proper hot holding temperatures

22

IN

OUTN/AFood proper cold holding temperatures

23

IN

OUTN/AN/OProper date marking & disposition

24

IN

OUT

N/A

N/OTime as a public health control: procedures & records

Consumer Advisory

25

IN

OUT

N/A

Consumer advisory provided for raw/undercooked food

Highly Susceptible Populations

26

IN

OUTN/AFood pasteurized foods used; prohibited foods not offered

Food and Color Additives and Toxic Substances

27

IN

OUT

N/A

Food additives: approved & properly used

28

IN

OUTToxic substances properly identified, stored, & used

Conformance with Approved Procedures

29

IN

OUT

N/A

Compliance with variance/specialized process/HACCP

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

GOOD RETAIL PRACTICES

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

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

Compliance Status

COS

R

Safe Food and Water

30

IN

OUTN/AFood pasteurized eggs used where required

31

IN

OUTN/AFood Water & ice obtained from an approved source

32

IN

OUT

N/A

Food Variance obtained for specialized processing methods

Food Temperature Control

33

IN

OUTN/AFood Proper cooling methods used; adequate equipment for temperature control

34

IN

OUTN/ADiv>

N/O

Plant food properly cooked for hot holding

35

IN

OUTN/AN/OFood Approved thawing methods used

36

IN

OUTN/AFood Thermometers provided & accurate

Food Identification

37

IN

OUTN/AFood Food properly labeled; original container

Prevention of Food Contamination

38

IN

OUTN/AFood Insects, rodents, & animals not present

39

IN

OUTN/AFood Contamination prevented during food prep, storage & display

40

IN

OUTN/AFood Personal cleanliness

41

IN

OUTN/AFood Wiping cloths: properly used & stored

42

IN

OUTN/AFood Washing fruits & vegetables

Compliance Status

COS

R

Proper Use of Utensils

43

IN

OUTN/AFood In-use utensils: properly stored

44

IN

OUTN/AFood Utensils, equipment & linens: properly stored, dried, & handled

45

IN

OUTN/AFood Single-use/single service articles: properly stored & used

46

IN

OUTN/AFood Gloves used properly

Utensil Equipment and Vending

47

IN

OUTN/AFood Food & non-food contact surfaces cleanable, properly designed, constructed, & used

48

IN

OUTN/AFood Warewashing facilities: installed, maintained, & used; test strips

49

IN

OUTN/AFood Non-food contact surfaces clean

Physical Facilities

50

IN

OUTN/AFood Hot & cold water available; adequate pressure

51

IN

OUTN/AFood Plumbing installed; proper backflow devices

52

IN

OUTN/AFood Sewage & waste water properly disposed

53

IN

OUTN/AFood Toilet facilities: properly constructed, supplied, & cleaned

54

IN

OUTN/AFood Garbage & refuse properly disposed; facilities maintained

55

IN

OUTN/AFood Physical facilities installed, maintained, & clean

56

IN

OUTN/AFood Adequate ventilation & lighting; designated areas used

57

IN

OUTN/AFood Compliance with MCIAA

58

IN

OUTN/AFood Compliance with licensing & plan review

Food Recalls:

Person in Charge (Signature)

Date: 02/27/24

Inspector (Signature)