



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

January 9, 2025

Licensee
Walnut Grove Home LLC
13708 Portland Avenue South
Chanhassen, MN 55317

RE: Project Number(s) SL40417015

Dear Licensee:

This is your **official notice** that you have been **granted your assisted living facility license**. 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.

The Minnesota Department of Health completed an initial survey on December 4, 2024, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

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.

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. The Department of Health documents state correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Home Care 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 are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

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

DOCUMENTATION OF ACTION TO COMPLY

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 residents/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **<https://forms.office.com/g/Bm5uQEPhVa>**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,



Renee Anderson, Supervisor

State Evaluation Team

Email: renee.anderson@state.mn.us

Telephone: 651-201-5871 Fax: 1-866-890-9290

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40417	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/04/2024
NAME OF PROVIDER OR SUPPLIER WALNUT GROVE HOME LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 13708 PORTLAND AVE S CHANHASSEN, MN 55317		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 000	Initial Comments ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL40417015-0 On December 3, 2024, through December 4, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were three residents; three receiving services under the provisional Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level pursuant to 144G.31 Subd. 1, 2 and 3.		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current	0 660			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 660	Continued From page 1 tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention and control program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included a two-step tuburculin skin test (TST) for one of two employees (unlicensed personnel (ULP)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-D was hired on May, 16, 2024, and provided direct cares to licensee residents. ULP-D's employee record included a single	0 660			

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0 660	Continued From page 2 negative TST dated May 1, 2024. The record lacked documentation a second TST was completed for ULP-D. On December 4, 2024, at 10:10 a.m., licensed assisted living director (LALD)-B verified a second step TST was not completed for ULP-D. LALD-B stated she would ensure ULP-D completed the two-step TST and include the results in the employee record. The licensee's TB Prevention and Control policy, dated March 8, 2024, verified the first step of the TST testing should be read within 48 to 72 hours of the initial skin test. The second TST should be repeated seven to 21 days after the first TST is read. "This two-step approach is used to reduce the likelihood that a boosted reaction to a subsequent TST will be misinterpreted as a recent infection." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660			
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	0 680			

Minnesota Department of Health

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0 680	Continued From page 3 all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to have a written emergency preparedness (EP) plan with all the required content. This had the potential to affect all three current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's EP plan, dated May 3, 2024, lacked individualized emergency procedures to include the following: -a risk assessment considering all hazards that may impact all or a portion of the facility;	0 680			

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0 680	Continued From page 4 - an assessment of the at risk population's needs; and - a process for emergency preparedness cooperation with state and local EP officials/organizations. On December 4, 2024, at 10:10 a.m., licensed assisted living director (LALD)-B and owner (O)-A verified the emergency preparedness plan lacked the above information and would ensure the information was included in the emergency preparedness plan for licensee residents. The licensee's Emergency and Disaster Preparedness policy, dated March 8, 2024, indicated "a hazard vulnerability assessement (HVA) has been completed to identify the most probable emergency situations that may be experienced by this facility or community." The policy directed "based on the HVA, an Emergency Preparedness Plan has been developed," and would include the above documentation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 780 SS=E	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate	0 780			

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0 780	Continued From page 5 sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide interconnected smoke alarms so that the actuation of one alarm causes all alarms in the dwelling unit to actuate. 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 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:	0 780			

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0 780	Continued From page 6 On December 4, 2024, from 10:35 a.m. through 11:03 a.m., during a facility tour with owner (O)-A, licensed assisted living director (LALD)-B, and registered nurse (RN)-C, the surveyor observed that the smoke alarms in resident sleeping rooms one and three were not interconnected with any other smoke alarms in the facility. All dwelling units required to have multiple smoke alarms are required to have interconnected alarms so activation of one alarm activates all alarms within the dwelling unit. During the tour the smoke alarms were tested by O-A. O-A verified the smoke alarms were not interconnected and stated that they would have the alarms checked and re-tested. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780			
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive	0 810			

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0 810	Continued From page 7 training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and failed to conduct the required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On December 4, 2024, at 11:10 a.m., owner (O)-A and licensed assisted living director	0 810			

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0 810	Continued From page 8 (LALD)-B provided documentation on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee's FSEP, titled "Fire Response Policy", dated March 1, 2024, failed to provide the following: The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include unique needs or evacuation status for each individual resident in writing and readily available for use in the event of a fire or similar emergency. LALD-A stated that this information was kept electronically. The surveyor explained that if the information is located somewhere other than in the plan, the plan needs to include instructions to staff so they know where to access the information. The FSEP did not include an evacuation map with a floor plan accurate to the building layout that showed the location and number of resident sleeping rooms. During an interview on December 4, 2024, at 11:27 a.m., O-A and LALD-B stated they understood the areas of the policy that were incomplete and would work on bringing them into compliance. TRAINING	0 810			

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0 810	Continued From page 9 Record review indicated the licensee failed to provide evacuation training based on the fire safety and evacuation plan to employees, at hire and twice per year. LALD-B provided documentation showing annual training and stated they train employees when they are hired and annually. The surveyor explained the requirement for training employees two times per year. During an interview on December 4, 2024, at 11:27 a.m., O-A and LALD-B stated they understood the requirement for employee training. DRILLS Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. Documents provided showed two evacuation drills were conducted in September 2024, and one drill was conducted in October 2024. Each work shift had participated in one drill. LALD-A stated that new ownership took over in June 2024 and they did not have records available prior to then. The surveyor asked if any drills were conducted between June and September 2024 and LALD-A stated they had not. During an interview on December 4, 2024, at 11:27 a.m., O-A and LALD-B stated they understood the requirement of conducting evacuation drills. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			

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01470	Continued From page 10	01470			
01470 SS=D	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 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 staff member 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	01470			

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01470	Continued From page 11 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 interview and record review, the licensee failed to ensure all required orientation content was provided to employees prior to the provision of services for one of two employees (registered nurse (RN)-C). 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:	01470			

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01470	Continued From page 12 RN-A was hired on May 15, 2024, and provided direct care nursing services to licensee residents. RN-A's record lacked documentation RN-A completed the following required orientation content: - an overview of 144G statutes; - an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; - review of the types of assisted living services the employee would provide and the provider's scope of license; and - principles of person-centered planning/service delivery -handling of emergencies and use of emergency services; -compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); -the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; -handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; and -consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services.	01470			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40417	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/04/2024
NAME OF PROVIDER OR SUPPLIER WALNUT GROVE HOME LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 13708 PORTLAND AVE S CHANHASSEN, MN 55317		
(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 13 On December 4, 2024, at 10:10 a.m., RN-A verified he had not completed the required orientation, and would ensure the training was completed and included in the employee record. The licensee's Assisted Living & Assisted Living with Dementia Care Orientation-All Staff policy, dated March 10, 2024, verified "all assisted living employees must complete an orientation to assisted living facility licensing requirements and regulations before providing services to residents." The policy included the above required trainings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470			
01530 SS=D	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial	01530			

Minnesota Department of Health

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01530	Continued From page 14 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 two employees (registered nurse (RN)-C) received the required dementia care training. 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: RN-A was hired on May 15, 2024, and provided supervisory and direct care nursing services for the licensee. RN-A's employee record lacked documentation he completed eight hours of initial dementia training within 120 working hours of employment start date. On December 4, 2024, at 10:10 a.m., RN-A	01530			

Minnesota Department of Health

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01530	Continued From page 15 verified he had previous training in dementia care but had not completed the required training and would ensure it was completed and included in the employee record. The licensee's Assisted Living Dementia Training policy, dated indicated, "supervisors of direct care staff will complete a minimum of eight hours of initial training on dementia care topics. The initial training will be completed within 120 hours of the employment start date." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530			
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees	01640			

Minnesota Department of Health

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01640	Continued From page 16 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 interview and record review, the licensee failed to ensure the current service plan included a signature or other authentication by the resident and the licensee to document agreement on the services to be provided for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1 was admitted June 21, 2024, and received services including medication administration, and assistance with cares. R1's service plan, dated December 4, 2024, lacked a signature or other authentication by the licensee and by the resident documenting agreement on the services to be provided. On December 11, 2024, at 4:49 p.m., licensed assisted living director (LALD)-B verified R1's service plan lacked a signature by the licensee and resident. LALD-B stated she was unable to locate the initial service plan which included R1's signature.	01640			

Minnesota Department of Health

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01640	Continued From page 17 The licensee's undated Contents of Service Plans policy indicated the service plans and any revisions to service plans would have a signature or other authentication by both the licensee and by the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640			
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned	01650			

Minnesota Department of Health

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01650	Continued From page 18 consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident service plan included the required content for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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: R1 was admitted June 21, 2024, and received services including assistance with medication administration, and activities of daily living (ADLs). R1's service plan, dated December 4, 2024, lacked the following information: -the frequency of each service, according to the resident's current assessment and resident preferences -the identification of staff or categories of staff who will provide the services; -the schedule and methods of monitoring assessments of the resident; -the schedule and methods of monitoring staff providing services; and -a contingency plan that includes: -the action to be taken if the scheduled	01650			

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01650	Continued From page 19 service cannot be provided; -information and a method to contact the facility; -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 -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. On December 11, 2024, at 4:49 p.m., licensed assisted living director (LALD)-B verified the service plan provided to all licensee residents lacked the required information. The licensee's undated Contents of Service Plans policy verified the service plan for licensee residents would include the above required documentation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650			



Minnesota Department of Health
Environmental Health, FPLS
P.O Box 64975
Saint Paul
651-201-4500

Type: Full
Date: 12/03/24
Time: 09:36:45
Report: 1018241211

Food and Beverage Establishment Inspection Report

Page 1

Location:

WALNUT GROVE HOME LLC
13708 Portland Avenue
Burnsville, MN55337
Dakota County, 19

Establishment Info:

ID #: 0029688
Risk: Low
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Matrix Advocare Network, Inc.

Phone #:
ID #: 53153

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

The following orders were issued during this inspection.

4-500 Equipment Maintenance and Operation

4-501.112A ** Priority 2 **

MN Rule 4626.0795A Maintain the temperature at the manifold of the hot water sanitizing rinse at a maximum temperature of 194 degrees F (90 degrees C) and no less than 165 degrees F (74 degrees C) for a single tank, stationary rack, single temperature machine or 180 degrees F (82 degrees C) for all other machines.

DISHWASHER TEST STRIP LEFT WITH ESTABLISHMENT INDICATED THAT A TEMPERATURE OF 160 WAS NOT REACHED DURING THE SANITIZING CYCLE OF THE MACHINE. COMPLY WITH RULE.

Comply By: 12/04/24

Food and Equipment Temperatures

Process/Item: Cold Holding

Temperature: 41 Degrees Fahrenheit - Location: REFRIGERATOR

Violation Issued: No

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

ESTABLISHMENT IS A RESIDENTIAL HOME WITH RESIDENTIAL EQUIPMENT.

ESTABLISHMENT IS DOING ALL SAME DAY SERVICE OF FOODS.

FLOORS, WALLS AND CEILINGS WERE OBSERVED TO BE IN GOOD CONDITION DURING THIS INSPECTION AND WILL BE MONITORED THROUGH THE YEARS.

KITCHEN HAS A TWO BASIN SINK AND ONE SINK SPECIFICALLY FOR HAND WASHING.

Type: Full
Date: 12/03/24
Time: 09:36:45
Report: 1018241211
WALNUT GROVE HOME LLC

Food and Beverage Establishment Inspection Report

Page 2

ESTABLISHMENT HAS A NEEDLE POINT THERMOMETER FOR CHECKING FOOD TEMPERATURES.

DISCUSSED PEST CONTROL AND ILLNESS REPORTING.

VIEWED ILLNESS LOG.

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 1018241211 of 12/03/24.

Certified Food Protection Manager: JINYI S WU

Certification Number: FM119749 Expires: 11/07/26

Inspection report reviewed with person in charge and emailed.

Signed: _____

DEBORAH ASHAMU
MANAGER

Signed: _____

Rebecca Prestwood
Sanitarian 3
6512013777
rebecca.prestwood@state.mn.us