DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF REMOVAL OF CONDITIONAL LICENSE

Electronic Delivery
May 10, 2023

Licensee
Scandia Capital Partners LLC
101 North 58th Avenue West
Duluth, MN 55807

RE: Initial License Number 408489
Health Facility Identification Number (HFID) 24431
Project Number(s) SL24431015

Dear Licensee:

On May 5, 2023, The Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found not corrected on the follow-up survey completed March 14, 2023, and monitoring visits completed February 5, 2023, and December 30, 2022, pursuant to the survey completed on November 23, 2022.

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.

Based on these findings, the condition(s) on the license were removed effective May 8, 2023.

Further, in accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders found not corrected at the time of the May 5, 2023, follow-up survey and/or subject to penalty assessment are as follows:

0680-Disaster Planning And Emergency Preparedness-144g.42 Subd. 10 - $500.00
0730-Contents Of Resident Record-144g.43 Subd. 3
1640-Service Plan, Implementation And Revisions To-144g.70 Subd. 4 (a-E) - $500.00
1650-Service Plan, Implementation And Revisions To-144g.70 Subd. 4 (f) - $500.00
1760-Documentation Of Administration Of Medication-144g.71 Subd. 8 - $500.00
1890-Prescription Drugs-144g.71 Subd. 20
1960-Documentation Of Administration Of Treatments-144g.72 Subd. 5

The details of the violations noted at the time of this follow-up survey completed on May 5, 2023 (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.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $2,000.00**. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document 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).

IMPOSITION OF FINES:

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

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 the 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.

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

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

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

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

Sincerely,

Maria King, RN
Division Director

Minnesota Department of Health
Health Regulation Division

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24431	A. BUILDING: _____ B. WING _____	R 05/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCANDIA CAPITAL PARTNERS LLC	101 NORTH 58TH AVENUE WEST DULUTH, MN 55807

(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: Project SL24431015 On May 4 and 5, 2023, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on November 23, 2022, monitoring call on December 30, 2022, monitoring visit dated February 5, 2023, and revist on March 14, 2023. At the time of the survey, there were six (6) receiving services under the Assisted Living with Dementia Care license. As a result of the revisit, the following orders were reissued and/or issued.	{0 000}	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	{0 480}		

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{0 480}	Continued From page 1 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: No further action required	{0 480}		
{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	{0 680}		

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{0 680}	Continued From page 2 by: Based on interview, and record review, the licensee failed to develop an emergency preparedness plan (EPP) with all required content. This had the potential to affect all residents, staff, and visitors of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 May 4, 2023, at 12:30 p.m., the surveyor reviewed the licensee's Emergency Plan revised April 23, 2023, with executive director (ED)-N. ED-N confirmed the licensee's EPP lacked the following required content. The licensee's EPP provided did not include the following: - a description of the facilities approach to meeting the health/safety/security needs of the staff and residents; - process for EP cooperation with state and local EP officials/organizations; - development of policies/procedures to address: - procedure for tracking staff and residents; - subsistence needs for staff and residents during an emergency to include (food, water, medical supplies, pharmacy supplies, sewer and waste disposal, emergency lighting, fire detection, extinguishing and alarm systems; - evacuation plan which included staff responsibilities during an evacuation;	{0 680}		

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{0 680}	Continued From page 3 - shelter in place; - a medical record documentation system to preserve resident information, security, and availability; and - the facilities role in providing care and treatment at alternative sites under a 1135 waiver. - a communication plan that included: - names and contact information for staff, other facilities, volunteers; - contact information for federal EP staff, and ombudsman; - primary and alternative means for communicating with facility staff, federal, state, regional and local emergency management agencies; - a method of sharing information and medical documentation for residents; - a means to provide information regarding the facility's needs, and its ability to provide assistance to include information about their occupancy; and - a method of sharing information from the EPP with residents and their families. The licensee's Emergency Plan policy revised March 30, 2023, indicated the licensee's assisted living director was responsible for maintaining an effective and current emergency preparedness plan and implementing procedures. No further information was provided.	{0 680}		
{0 730} SS=E	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number;	{0 730}		

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{0 730}	Continued From page 4 (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this	{0 730}		

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{0 730}	Continued From page 5 chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the license failed to ensure documentation of significant changes in the resident's status and actions taken in response to the needs of the resident for one of one resident (R7) and failed to ensure documentation of services that have been provided as identified in the service plan for two of four residents (R5, R7). 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: DOCUMENTATION OF SIGNIFICANT CHANGES IN THE RESIDENT STATUS AND ACTION TAKEN R7 R7 was admitted for services on November 8, 2013. R7's May 2023, Care Plan indicated R7 received assistance with medication administration, bathing, dressing, toileting, housekeeping and laundry.	{0 730}		

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{0 730}	Continued From page 6 R7's Progress Notes (written by the registered nurse (RN)) dated March 28, 2023, indicated R7 requested to speak to the nurse. R7 pointed out a few sores on R7's left forearm and hand that were open and bleeding. R7 refused to let the RN apply Bacitracin and a bandage to the open areas. R7's record lacked any further documentation pertaining to the open areas on R7's left forearm. On May 4, 2023, at 10:00 a.m., RN-P stated she had monitored the open areas on R7's left forearm daily but did not document the monitoring in R7's record. DOCUMENTATION OF SERVICES R5 R5's diagnosis included hypothyroidism, heart murmur, memory loss and chronic neck pain. R5's record lacked a service plan. R5's April and May 2023 care plans, indicated weights and vital signs were to be performed weekly. R5's April 2023 Daily Monitoring Flowsheet's indicated the following: - weights and vital signs were not documented two out of four opportunities. R7 R7's diagnosis included cerebral vascular disease (CVA) and atrial fibrillation. R7's record lacked a service plan. R7's May 2023 care plan, indicated daily weights were to be performed. R7's May 2023 Daily Monitoring Flowsheet's	{0 730}		

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{0 730}	Continued From page 7 indicated the following: - daily weights were not documented four out of four opportunities. On May 4, 2023, at 10:00 a.m., executive director (ED)-N and RN-P confirmed the above-mentioned documentation was missing from R5 and R7's record. RN-P stated she had performed audits of staff documentation and noted documentation continued to be missing. RN-P stated she would have to address the issue with staff. The licensee's undated Client Record policy indicated the client record should include documentation of services provided in the service, medication, treatment, and care plan. No further information provided.	{0 730}		
{01640} SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan.	{01640}		

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{01640}	Continued From page 8 (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 interview and record review, the licensee failed to ensure a current written service plan was finalized no later than 14 calendar days after the date that services were first provided, for three of three residents (R9, R5, R7). 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: R9 R9 was admitted on November 14, 2022, and received services under the licensee's assisted living with dementia care license. R9's diagnoses included congestive heart failure (CHF- condition in which the heart's function as a pump is inadequate to meet the body's needs), depression, and edema. R9's Care Plan dated May 2023, indicated R9 required total assist with bath/shower one day a week or more as needed (PRN), assist with	{01640}		

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{01640}	Continued From page 9 dressing in the morning and evening, 1 staff to supervise/assist for safety in ambulation 10 times a day, and 1 staff to supervise/assist with toileting every 2 hours (10 times per day). R9's Medication Management Plan: Addendum to Service Plan, dated November 14, 2022, indicated R9 required assistance with medication administration. R9's Treatment Plan: Addendum to Service Plan, November 14, 2022, indicated R9 required assistance with compression stockings (TEDs), creams, and staff to set up C-pap [noninvasive ventilation breathing support through a face mask, nasal mask, or helmet]. R9's record lacked a service plan. R5 R5 was admitted to the assisted living facility on September 1, 2020. R5's diagnoses included hypothyroidism, heart murmur, memory loss and chronic neck pain. R5's care plan dated May 2023 indicated services included: medication administration, assistance with bathing, grooming and dressing, and light housekeeping. R5's record lacked a service plan. R7 R7 was admitted to the assisted living facility on November 8, 2013. R7's diagnoses included cerebral vascular disease (CVA) and atrial fibrillation.	{01640}		

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{01640}	Continued From page 10 R7's care plan dated May 2023, indicated services included medication administration, bathing, daily weights, weekly vital signs , laundry and housekeeping. R7's record contained a service plan that was not dated, completely filled out and not signed by the resident or the resident's representative. On May 4, 2023, at 9:00 a. m., executive director (ED)-N stated they were unable to find a service plan for R9 and R5. In addition, ED-N confirmed R7's service plan was not completely filled out, not dated, and not signed by the resident or the resident's representative. The licensee's Service Plans policy, dated May 9, 2019, indicated beginning with the initiation of services, a service plan was developed for the client based on an agreement with the client/responsible party and on the assessed needs identified in the comprehensive assessment. The service plan would be finalized no later than 14 days after the initiation of services, if not already completed. No further information was provided.	{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	{01650}		

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{01650}	Continued From page 11 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 interview and record review, the licensee failed to ensure the service plan included the required content for one of one resident (R2). This had the potential to affect all residents who received services at the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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:	{01650}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24431	A. BUILDING: _____ B. WING _____	R 05/05/2023

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{01650}	Continued From page 12 R2's diagnoses included hyperthyroidism, hyperlipidemia (high cholesterol), hypertension (HTN-high blood pressure), and congestive heart failure (CHF-condition in which the heart's function as a pump is inadequate to meet the body's needs). R2's service and care plans, dated September 1, 2022, and March 1, 2023, respectively, indicated services included: medication management (with four times daily medication administration), weekly showers with standby assist of 1 staff, monitoring of weight and blood pressure (BP), and treatment of compression stockings (TEDs) application and removal. R2's Service Plan lacked the following required content: - the method of monitoring staff providing services. On May 4, 2023, at 12:30 p.m., executive director (ED)-N and licensed assisted living director in residence (LALD-IR)-R stated R2's service plan was incomplete and did not include the above noted content. LALD-IR-R stated they have developed a new services plan template that includes the method of monitoring staff providing services, but they have not implemented the new service plan at this time. The licensee's Service Plans policy dated May 9, 2019, indicated the service plan included: -a description of the home care services to be provided; the service description may be in the form of the client's care plan developed with the client/responsible party; -the fees for services and the frequency of each service, according to the client's current review or assessment and client preferences;	{01650}		

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{01650}	Continued From page 13 -the identification of the staff or categories of staff who would provide the services; -the schedule and methods of monitoring review of assessments of the client; -the frequency of sessions of supervision of staff and type of personnel who would supervise staff; and -a contingency plan. No further information was provided.	{01650}		
{01760} SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to administer medication as ordered by prescriber for three of four residents (R9, R3, R7). 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	{01760}		

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{01760}	Continued From page 14 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: R9 R9's diagnoses included congestive heart failure (CHF)- condition in which the heart's function as a pump is inadequate to meet the body's needs), depression, and edema. R9's record lacked a service plan. R9's Care Plan dated May 2023, indicated R9 required assistance with medication administration. R9's prescriber orders, dated March 23, 2023, included Triamcinolone 0.1% topical cream, apply twice a day to itchy spots on lower legs and feet. One week on and one week off. Eucerin 1% topical cream, apply to back and legs twice a day, alternating weeks with Triamcinolone cream. R9's April 2023, medication administration record (MAR) indicated on April 3, 2023, to April 16, 2023, R9 received both the Triamcinolone 0.1% tropical cream and the Eucerin 1% topical cream. On May 4, 2024, at 10:00 a.m., executive director (ED)-N and registered nurse (RN)-P stated R9's tropical creams were both administered to R9 from April 3, 2023, to April 16, 2023. R3 R3's diagnoses included CHF, and coronary artery disease (CAD)	{01760}		

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{01760}	Continued From page 15 R3's May 2023, Care Plan indicated R3 received assistance with medication administration. R3's prescriber orders, dated October 20, 2022, included atorvastatin (cholesterol reduction) 40 milligrams (mg) daily, bupropion (antidepressant) 200 mg twice a day, metoprolol (treat atrial fibrillation) 25 mg every evening, and ropinirole (treat restless legs) 0.25 mg at bed time. R3's May 2023, MAR indicated the following medications were not administered: -atorvastatin 40 mg two out of three opportunities; -bupropion 200 mg (4:00 p.m. dose) one out of three opportunities; -metoprolol 25 mg (4:00 p.m. dose) one out of three opportunities; and -ropinirole 0.25 mg one out of three opportunities. R7 R7's diagnoses included cerebral vascular disease (CVA) and atrial fibrillation. R7 May 2023, Care Plan indicated R7 required assistance with medication administration. R7's prescriber orders, dated December 16, 2022, included folic acid 1 mg daily, famotidine (anti acid) 2 mg twice daily, furosemide (diuretic) 20 mg daily, Mag Oxide 420 mg twice daily, and metoprolol 50 mg twice a day. R7's April 2023, MAR indicated the following medication were not administered: -famotidine 2 mg, (5:00 p.m. dose) two out of thirty (30) opportunities; -furosemide 20 mg one out of thirty (30) opportunities; -Mag Oxide 420 mg two out of thirty opportunities; and	{01760}		

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{01760}	Continued From page 16 -metoprolol 50 mg (5:00 p.m. dose) two out of thirty (30) opportunities. On May 4, 2023, at 10:00 a.m. ED-N and RN-P confirmed R3 and R7's medications were not administered as indicated above. RN-P stated she had been auditing resident MARs and continued to find omissions of documentation. The licensee's Medication Documentation policy dated February 7, 2019, indicated if an administration of a medication was not completed staff will document the following: -the reason why the medication was not administered; -follow up procedure to meet the client's needs in compliance with the medication management plan; and -appropriate notification to the registered nurse (RN) supervisor or other persons as instructed regarding missed dosages No further information was provided.	{01760}		
{01890} SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to date time-sensitive medications with an opened or expiration date for	{01890}		

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{01890}	Continued From page 17 one of two residents (R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On May 4, 2023, at 10:30 a.m., the surveyor reviewed the medication cart with executive director (ED)-N confirming the following: -R5's Polyvinyl Al solution 1.4% eye drops, stored in the top drawer of the medication cart, did not include a date when the medication was opened. The manufactures package insert dated July 15, 2009, indicated you must throw away the bottle 28 days after you first open the bottle, even if there are still some drops left in the bottle. The licensee's Storage/Control of Medications policy dated February 7, 2019, indicated medication is labeled completely and legibly. The medication label should contain the following: prescription number and name of medication, strength and quantity, expiration date for time-dated drugs, directions for use, resident's name, prescriber's name, date issues, and name and address of licensed pharmacy issuing the medication. No further information was provided.	{01890}		

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{01960}	Continued From page 18	{01960}		
{01960} SS=E	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure treatment or therapies were administered as directed three residents (R7, R9). 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: R7 R7's diagnoses included cerebral vascular disease (CVA) and atrial fibrillation. R7's April 2023 care plan indicated R7 was to	{01960}		

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{01960}	Continued From page 19 received oxygen at two (2) liters per nasal cannula at night. R7's prescriber orders, dated December 16, 2022, included oxygen at two (2) liters at night. R7's April 2023, treatment management record (TMR) indicated R7's oxygen was not applied four (4) out of thirty (30) opportunities. R9 R9's diagnoses included congestive heart failure (CHF-condition in which the heart's function as a pump is inadequate to meet the body's needs), depression, and edema. R9's record lacked a service plan. R9's Care Plan dated May 2023, indicated R9 required assistance with TED (compression stockings). The TEDs were to be applied in the morning and removed at night. R9's April 2023 TMR indicated R9's TEDs were not applied ten (10) out of thirty (30) days. On May 4, 2023, at 10:00 a.m. executive director (ED)-N confirmed R7 and R9's treatments were not administered as indicated above. The licensee's Treatment and Therapy Management policy dated May 9, 2019, indicated the facility would use treatment and therapy protocols consistent with current evidence-based practice standards and guidelines. The registered nurse (RN) was responsible for assessing and developing the treatment and/or therapy service plan for clients. When the RN delegates treatments or therapies, the professional would monitor and evaluate its effectiveness on a regular basis as specified in the service plan.	{01960}		

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{01960}	Continued From page 20 Each staff member who administers a treatment or therapy was responsible for documenting this in the clinical record. When a treatment or therapy was not administered as ordered or prescribed, staff would document the reason why it was not administered, and any follow-up procedures provided to meet the client's needs. No further information was provided.	{01960}		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF EXTENDED CONDITIONAL LICENSE AND SURVEY RESULTS

Electronically Delivered

March 20, 2023

Licensee
Scandia Capital Partners, LLC
101 North 58th Avenue West
Duluth, MN 55807

RE: Conditional License Number 408489
Health Facility Identification Number (HFID) 24431
Project Number(s) SL24431015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a follow-up evaluation on March 14, 2023, to determine correction of orders found not corrected during the monitoring visits completed on February 2 - 5, 2023 and December 30, 2022, pursuant to the licensing evaluation completed on November 23, 2022. This follow-up licensing evaluation determined your facility continues to not be in substantial compliance with state licensing orders pursuant to the laws of Minnesota Statute, Chapter 144G and Minnesota Food Code, Minnesota Rules Chapter 4626.

As a result, MDH is extending the conditional license 60-days, due to expire on **May 19, 2023**.

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

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

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

Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

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

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

St - 0 - 0250 - 144g.20 Subdivision 1 - Conditions - $500.00
St - 0 - 0480 - 144g.41 Subd 1 (13) (i) (b) - Minimum Requirements - $500.00
St - 0 - 0630 - 144g.42 Subd. 6 (b) - Compliance With Requirements For Reporting Ma - $500.00
St - 0 - 0680 - 144g.42 Subd. 10 - Disaster Planning And Emergency Preparedness - $500.00
St - 0 - 0730 - 144g.43 Subd. 3 - Contents Of Resident Record
St - 0 - 0810 - 144g.45 Subd. 2 (b)-(f) - Fire Protection And Physical Environment - $500.00
St - 0 - 1370 - 144g.61 Subd. 2 (a) - Training And Evaluation Of Unlicensed Personn
St - 0 - 1380 - 144g.61 Subd. 2 (b) - Training And Evaluation Of Unlicensed Personn
St - 0 - 1620 - 144g.70 Subd. 2 (c-E) - Initial Reviews, Assessments, And Monitoring - $500.00
St - 0 - 1640 - 144g.70 Subd. 4 (a-E) - Service Plan, Implementation And Revisions To
St - 0 - 1650 - 144g.70 Subd. 4 (f) - Service Plan, Implementation And Revisions To - $500.00
St - 0 - 1760 - 144g.71 Subd. 8 - Documentation Of Administration Of Medication
St - 0 - 1790 - 144g.71 Subd. 10 - Medication Management For Residents Who Will
St - 0 - 1890 - 144g.71 Subd. 20 - Prescription Drugs
St - 0 - 1950 - 144g.72 Subd. 4 - Administration Of Treatments And Therapy
St - 0 - 1960 - 144g.72 Subd. 5 - Documentation Of Administration Of Treatments
St - 0 - 2040 - 144g.81 Subdivision 1 - Fire Protection And Physical Environment - $500.00
St - 0 - 2110 - 144g.82 Subd. 3 - Policies - $500.00
St - 0 - 2170 - 144g.84 - Services For Residents With Dementia - $500.00

Also, at the time of this follow-up evaluation completed on March 14, 2023, we identified the following violation(s):

0690-Resident Record-144g.43 Subdivision 1
0900-Contract Required-144g.50 Subdivision 1

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

The total amount you are assessed is $5,000.00. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

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

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

CONDITIONAL LICENSE ISSUED:
MDH will issue Scandia Capital Partners LLC an extension to the conditional assisted living facility license by an additional 60 calendar days from the date of this notice. At an unannounced point in time, within the 60 calendar days, MDH will conduct a follow-up evaluation, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the follow-up evaluation, MDH will determine if Scandia Capital Partners LLC is in substantial compliance.

The following conditions will remain in effect through the extended conditional assisted living facility license:

a. **No new substantiated maltreatment allegations:** If any new investigations begin in the conditional license period, and the allegations are substantiated, MDH may pursue additional enforcement actions up to and including immediate temporary suspension and revocation of the license.

b. **No new admissions:** Scandia Capital Partners LLC will continue to not admit any new residents under its conditional assisted living facility license until the MDH removes the “no new admissions” condition.

c. Consultant: Scandia Capital Partners LLC will continue to contract with an RN to provide consultation concerning all resident(s) to whom Scandia Capital Partners LLC provides licensed assisted living services under the conditional license. The consultant must continue to have access to all resident(s) receiving services from Scandia Capital Partners LLC. The consultant will continue to 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. Scandia Capital Partners LLC will continue to be responsible for the expense of the contract with the RN. The main purpose of the consultant is to continue to provide guidance to Scandia Capital Partners LLC in an effort to help Scandia Capital Partners LLC 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. Scandia Capital Partners LLC will continue to 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 continue to provide MDH with regular reports. The reports will continue weekly until MDH notifies Scandia Capital Partners LLC and the RN consultant about a change. Each report will continue to be electronically submitted to Jessica Chenze, Evaluator Supervisor, State Evaluation Team, Health Regulation Division, at jessica.chenze@state.mn.us. Jessica Chenze can be reached at 218-332-5175 (office) with questions about reports. The content of the reports will continue to include information such as:

i. Progress towards correction of licensing 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 Scandia Capital Partners LLC to correct the violations cited during the evaluation as well as to determine the overall practice of Scandia Capital Partners LLC 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 licensed assisted living services. The OOLTC will share their findings with MDH.

f. Follow-up Evaluation: At the time of the follow-up evaluation, MDH may pursue additional enforcement actions, up to and including immediate temporary suspension or revocation of the license if MDH identifies any level 3 or 4 violations or widespread care related violations.

g. Corrective Action Plan: Scandia Capital Partners LLC will continue to 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 LICENSE PERIOD:

MDH will determine if Scandia Capital Partners LLC is in substantial compliance based on the results of the follow up evaluation. MDH will make this determination within the extended 60-day conditional license period. If MDH determines Scandia Capital Partners LLC is in substantial compliance on the follow up evaluation, MDH will remove the conditions from Scandia Capital Partners LLC's assisted living facility license, and Scandia Capital Partners LLC will correct violations identified during the evaluation to come into substantial compliance. If MDH determines Scandia Capital Partners LLC is not in substantial compliance, MDH may take additional enforcement action against Scandia Capital Partners LLC, including placement of additional conditions, issuing a second conditional license, or employ any of the enforcement tools listed in Minn. Stat. § 144G.20 up to and including immediate temporary suspension and revocation.

REQUESTING A HEARING:

Pursuant to Minn. Stat. §144G.20, Subd. 17 (c), the licensee may appeal an order immediately temporarily suspending a license or issuing a conditional license. The appeal must be made in writing by certified mail or personal service. If mailed, the appeal must be postmarked and sent to the commissioner within five calendar days after the license holder receives notice. If an appeal is made by personal service, it must be received by the commissioner within five calendar days after the

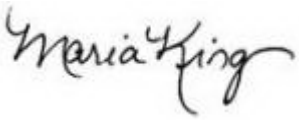
license holder received the order. The request for hearing should be addressed to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970
Health.HRD.Appeals@state.mn.us

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this notice and the results of this visit with the President of your organization's Governing Body.

If you have any questions, please contact Jessica Chenze directly at: 218-332-5175.

Sincerely,



Maria King, RN
Division Director
Minnesota Department of Health Health Regulation Division

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24431	A. BUILDING: _____ B. WING _____	R 03/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCANDIA CAPITAL PARTNERS LLC	101 NORTH 58TH AVENUE WEST DULUTH, MN 55807

(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: Project SL24431015 On March 7, 2023, through March 14, 2023, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on November 23, 2022, monitoring call on December 30, 2022, and monitoring visit dated February 5, 2023. At the time of the survey, there were seven (7) receiving services under the Assisted Living with Dementia Care license. As a result of the revisit, the following orders were reissued and/or issued.	{0 000}	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
{0 250} 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}		

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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: During the entrance conference on March 7, 2023, at 9:15 a.m. executive director (ED)-N,	{0 250}		

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{0 250}	Continued From page 3 licensed assisted living director (LALD)-L, and registered nurse consultant (RNC)-O stated they were familiar with the assisted living regulations and the licensee provided medication and treatment management services. The licensee's Application for Assisted Living License, section titled Official Verification 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. [Minnesota] Stat. [statute] sect. [section] 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 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	{0 250}		

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{0 250}	Continued From page 4	{0 250}		

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 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

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{0 250}	Continued From page 5 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 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 five was electronically signed by regional director/licensed practical nurse (RD/LPN)-D on May 12, 2022. The licensee had an assisted living license issued on August 1, 2022, with an expiration date of April 30, 2023. The licensee failed to ensure the following policies and procedures were developed and/or implemented: (1) requirements in section 626.557, reporting of maltreatment of vulnerable adults; (2) training, and competency evaluations of staff, and a process for evaluating staff performance; (5) conducting initial evaluations of residents' needs and the providers' ability to provide those services; (6) 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; (7) medication and treatment management; and	{0 250}		

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{0 250}	Continued From page 6 (8) delegation of tasks by registered nurses or licensed health professionals; On March 7, 2023, at 1:00 p.m., ED-N stated they failed to implement the following policies: reporting of maltreatment of vulnerable adults, training, and competency evaluations of staff, conducting initial evaluations of residents' needs and the providers' ability to provide those services, 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, medication and treatment management, delegation of tasks by registered nurses, and failed to implement corresponding policies and procedures, as required. As a result of this survey, the following orders were issued 0250, 0480, 0630, 0680, 0690, 0730, 0810, 0900, 1370, 1380, 1620, 1640, 1650, 1760,1790, 1890, 1950, 1960, 2040, 2110, and 2170 indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided.	{0 250}		
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and	{0 480}		

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{0 480}	Continued From page 7 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This had the potential to affect all seven (7) residents in the Assisted Living facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report, dated March 8, 2023, for the specific Minnesota Food Code deficiencies.	{0 480}		
{0 630} SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse.	{0 630}		

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{0 630}	Continued From page 8 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop an individual abuse prevention plan with all required content for three of four residents (R5, R7, R9). 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: R5 R5 was admitted to the assisted living facility on September 1, 2020. R5's diagnosis included hypothyroidism, heart murmur, memory loss, and chronic neck pain. R5's March 2023 care plan indicated services included: medication administration, assistance with bathing, grooming and dressing, and light housekeeping. R5's Vulnerability Assessment dated February 7, 2023, indicated R5 was vulnerable in the following areas: environment safe/clean; visual difficulties, hearing difficulties; understands/follow instructions; able to ambulate safely with/without device; ability to use phone; ability to manage finances; social support system; and ability to report abuse/neglect concerns. The Vulnerability	{0 630}		

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{0 630}	Continued From page 9 Assessment indicated to complete an Individual Abuse Prevention Plan for all areas marked "Yes". A plan to minimize the risk of abuse/neglect may also be established in the Care plan for each vulnerable area identified in this assessment. On March 8, 2023, at 6:52 a.m., the evaluator observed unlicensed personnel (ULP)-J complete medication administration for R5. R5's Vulnerability Assessment dated February 7, 2023, and R5's Care Plan for March 2023, did not include a plan to minimize the risk of abuse/neglect for each vulnerable area identified in the Vulnerability Assessment. R7 R7 was admitted to the assisted living facility on November 8, 2013. R7's March 2023 Care Plan indicated R7 received assistance with medication administration, bathing, housekeeping and laundry. R7's Vulnerability Assessment dated February 7, 2023, indicated R7 was vulnerable in the following areas: oriented to person, place and time; environment safe/clean' understanding and following directions; ability to safely with/without a device; ability to use the telephone; and ability to report abuse/neglect concerns. The Vulnerability Assessment indicated to complete an Individual Abuse Prevention Plan for all areas marked "Yes". A plan to minimize the risk of abuse/neglect may also be established in the Care plan for each vulnerable area identified in this assessment.	{0 630}		

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{0 630}	Continued From page 10 R7's Vulnerability Assessment dated February 7, 2023, and R7's Care Plan for March 2023, did not include a plan to minimize the risk of abuse/neglect for each vulnerable area identified in the Vulnerability Assessment. R9 R9 was admitted to the assisted living facility on November 14, 2022. R9's March 2023 Care Plan indicated R7 received assistance with medication administration, bathing, dressing, transfers, housekeeping and laundry. R9's Vulnerability Assessment dated February 7, 2023, indicated R9 was vulnerable in the following areas: environment safe/clean; understands/follow instructions; able to ambulate safely with/without device; chronic conditions/pain/illness/disability; ability to use phone; possesses functional limitations; and ability to report abuse/neglect concerns. The Vulnerability Assessment indicated to complete an Individual Abuse Prevention Plan for all areas marked "Yes". A plan to minimize the risk of abuse/neglect may also be established in the Care plan for each vulnerable area identified in this assessment. On March 8, 2023, at 7:06 a.m., the evaluator observed ULP-J complete medication administration for R9. R9's Vulnerability Assessment dated February 7, 2023, and R9's Care Plan for March 2023, did not include a plan to minimize the risk of abuse/neglect for each vulnerable area identified in the Vulnerability Assessment.	{0 630}		

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{0 630}	Continued From page 11 On March 9, 2023, at 9:00 a.m., executive director (ED)-N confirmed R5, R7 and R9's March 2023 Care Plans did not include a plan to minimize the risk of abuse/neglect for each vulnerable area identified in the Vulnerability Assessment. The licensee's Assessment - Comprehensive Services policy, dated August 1, 2021, indicated an individualized initial evaluation of all new clients shall be completed on admission by a registered nurse (RN) in order to develop a personalized service plan. The policy directed the RN will provide the admission visit and conduct assessment, including a vulnerability assessment. The policy did not describe content of the vulnerability assessment. No further information was provided.	{0 630}		
{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	{0 680}		

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	24431	A. BUILDING: _____ B. WING _____	R 03/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{0 680}	Continued From page 12 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 develop an emergency preparedness plan (EP) with all required content or practice and document testing of its plan at least twice annually as required. In addition, the licensee failed to ensure its missing resident plan had all required content and evaluate/revise its plan at least quarterly. This had the potential to affect all seven (7) residents, staff and visitors of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: During the entrance conference on March 7, 2023, at 9:15 a.m., the evaluator requested to view the facility's emergency plan and related documentation, which was later provided. EMERGENCY PREPAREDNESS PLAN	{0 680}		

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{0 680}	Continued From page 13 On March 7, 2023, at 1:00 p.m. Executive director (ED)-N provided the licensee's Emergency Plan revised February 28, 2023. ED-N stated the Emergency Plan was not completed. ED-N stated they still needed contracts signed with a transportation company and a temporary shelter until the emergency has resided. The licensee's emergency preparedness plan lacked the following components: -description of the population served by licensee; -process for emergency preparedness cooperation with state and local EP officials/organizations; -subsistence needs for staff and residents during emergency situation; -procedure for tracking staff and residents; -development of all policies/procedures, based on assessment; and additional policies for: -sheltering in place; -handling and use of volunteers; -arrangement with other faculties (including sister facilities); -development of a communication plan, including primary and alternate means for communication; -methods for sharing information; -EP training and testing program; -EP training program for staff (including documentation of training provided); and -annual EP testing requirements. MISSING PERSON POLICY The evaluator reviewed the facility's Missing Resident policy, dated March 7, 2023. The policy lacked required content including:	{0 680}		

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{0 680}	Continued From page 14 -identify a staff member for each shift who is responsible for implementing the missing resident plan, and ensure at least one staff member who is responsible for implementing the missing-resident plan is on site 24 hours a day, seven days a week. On March 7, 2023, at 4:17 p.m., ED-N stated the Missing Resident policy was not individualized by the facility and was missing the content noted above. No further information was provided.	{0 680}		
0 690 SS=D	144G.43 Subdivision 1 Resident record (a) Assisted living facilities must maintain records for each resident for whom it is providing services. Entries in the resident records must be current, legible, permanently recorded, dated, and authenticated with the name and title of the person making the entry. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to maintain records for one of one resident (R2) for whom they provided services, including authentication of documentation with the name and title of the person completing the resident assessment. 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	0 690		

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0 690	Continued From page 15 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's diagnoses included hyperthyroidism, hyperlipidemia (high cholesterol), hypertension (HTN-high blood pressure), and congestive heart failure (CHF-condition in which the heart's function as a pump is inadequate to meet the body's needs). R2's service and care plans, dated September 1, 2022 and March 1, 2023 respectively, indicated services included: medication management (with four times daily medication administration), weekly showers with standby assist of 1 staff, monitoring of weight and blood pressure (BP), and treatment of compression stockings (TEDs) application and removal. On March 8, 2023, at 7:45 a.m., the evaluator observed unlicensed personnel (ULP)-J complete medication administration for R2. R2's Registered Nurse (RN) Comprehensive Assessment dated February 10, 2023, was not authenticated with the name and title of the person completing the assessment. On March 8, 2023, at 12:33 p.m., executive director (ED)-N confirmed R2's RN Comprehensive Assessment noted above was not authenticated with the name and title of the person completing the assessment and should have been signed with name and title of the RN. The licensee's undated Client Record policy indicated all nursing notes entries must be dated, legible and signed by writer, including credentials.	0 690		

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0 690	Continued From page 16 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 690		
{0 730} SS=E	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the	{0 730}		

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{0 730}	Continued From page 17 needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the license failed to ensure documentation of significant changes in the resident's status and actions taken in response to the needs of the resident for one of one resident (R7) and failed to ensure documentation of services that have been provided as identified in the service plan for three of four residents (R2, R5, R9). 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:	{0 730}		

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{0 730}	Continued From page 18 DOCUMENTATION OF SIGNIFICANT CHANGES IN THE RESIDENT STATUS AND ACTION TAKEN R7 On March 7, 2023, at 11:00 a.m., executive director (ED)-N provided a current resident roster for review. ED-N stated R7 was currently in the hospital. On March 8, 2023, at 7:15 a.m., unlicensed personnel (ULP)-J stated R7 was in the hospital. ULP-J stated R7 had been in the hospital for a few days. R7 returned from the hospital and in less that twenty-four (24) hours R7 had a change in condition, the registered nurse (RN) was called and R7 was transferred to the emergency room and was again admitted to the hospital. ULP-J was not sure of the exact dates. On March 8, 2023, at 9:00 a.m., the evaluator requested documentation pertaining to R7's recent hospitalization. The only documentation provided by registered nurse consultant (RNC)-O was an Interagency Referral Form indicating R7 was admitted on February 25, 2023, with a principal diagnosis of severe sepsis with septic shock. RNC-O stated she was not on site when R7 returned from the hospital. RNC-O interviewed staff and shared the following information pertaining to R7: -On February 22, 2023, at around 1:00 p.m., R7's "face not moving good, eye rolling, slurring words and was not processing directives". R7 was taken by ambulance to the hospital. Hospital diagnosis included transient weakness of left lower extremity and anticoagulated. -On February 24, 2023, R7 returned from the hospital. Per staff member R7 was walking,	{0 730}		

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{0 730}	Continued From page 19 talking, eating. R7 was a baseline prior to hospitalization by staff. -On February 25, 203, at around 5:00 p.m., R7 was at the supper table and stood up, eye rolled back, slurred speech. The ULP had resident sit back down. Oxygen saturation level was 69% (normal above 90%). ULP called the RN on call. Ambulance came and transported R7 to the hospital. Hospital diagnosis included pneumonia of right lower lobe due to infectious organism versus pneumonitis versus mucous plug, metabolic encephalopathy, and severe sepsis with septic shock. -On March 2, 2023, family transported resident from the hospital, arriving at the building around 1:00 p.m. The family stopped to let facility know they were taking the resident out for a while and would bring him back. RN on call was on her way. The family brought R7 back before RN arrived. Coordinated with the RN to do an assessment upon resident's return. Staff noted R7 "did not appear well". R7 was pale, "ashy" in appearance unable to ambulate. R7's blood pressure was 70/50. The RN on call was notified and indicated to call EMS (emergency medical services). EMS transported back to the family. The hospital diagnosis was staphylococcus epidermidis bacteremia (bacterial infection). R7's record lacked evidence of documentation pertaining to the above information provided by RNC-O. On March 8, 2023, at 9:00 a.m., RNC-O confirmed R7's record lacked documentation pertaining to the above information provided by RNC-O. DOCUMENTATION OF SERVICES	{0 730}		

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{0 730}	Continued From page 20 R2 R2's diagnoses included hyperthyroidism, hyperlipidemia (high cholesterol), hypertension (HTN-high blood pressure), and congestive heart failure (CHF-condition in which the heart's function as a pump is inadequate to meet the body's needs). R2's service and care plans, dated September 1, 2022, and March 1, 2023, respectively, indicated services included: medication management (with four times daily medication administration), weekly showers with standby assist of 1 staff, monitoring of weight and blood pressure (BP), and treatment of compression stockings (TEDs) application and removal. On March 8, 2023, at 7:45 a.m., the evaluator observed ULP-J complete medication administration for R2. R2's Care Plan had caregiver documentation to complete on morning (a.m.), evening (p.m.), and night shifts. From March 1, 2023, through March 6, 2023: -two out of six opportunities were not documented on the p.m. shift of cares provided R5 R5's diagnosis included hypothyroidism, heart murmur, memory loss and chronic neck pain. R5's record lacked a service plan. R5's care plan, dated March 1, 2023, indicated services included: medication administration, assistance with bathing, grooming and dressing, and light housekeeping. On March 8, 2023, at 6:52 a.m., the evaluator observed ULP-J complete medication	{0 730}		

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{0 730}	Continued From page 21 administration for R5. R5's Care Plan had caregiver documentation to complete on a.m., p.m., and night shifts. From March 1, 2023, through March 6, 2023: -four out of six opportunities were not documented on the p.m. shift of cares provided. R9 R9's diagnosis included congestive heart failure. R9 lacked a service plan. R9's March 2023, Care Plan indicated R9 required total assist with bath/shower one day a week or more as needed (PRN), assist with dressing in the morning and evening, 1 staff to supervise/assist for safety in ambulation 10 times a day, and 1 staff to supervise/assist with toileting every 2 hours (10 times per day). At the bottom the R9's March 2023, care plan was a place for caregiver documentation. It noted "I have been oriented to the cares above and have completed then as required. I will notify RN if client changes occur." R9's March 2023 Care Plan lacked documentation of the services provided from March 1, 2023, to March 6, 2023, by the caregiver. (on all three shifts). On March 8, 2023, at 10:00 a.m., RNC-O stated that she had completed audits pertaining to ULP documentation and also found that R9's Care Plan lacked documentation of services provided as indicated above. RNC-O also stated R2 and R5's services were not documented as indicated above. The licensee's undated Client Record policy indicated the client record should include documentation of services provided in the	{0 730}		

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{0 730}	Continued From page 22 service, medication, treatment, and care plan. No further information provided.	{0 730}		
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.	{0 810}		

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{0 810}	Continued From page 23 This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to maintain the facility's fire safety and evacuation plan with required elements. 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). A record review of available documentation and interview were conducted on March 14, 2023, at approximately 9:30 a.m. of documents provided by executive director (ED)-N on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Findings include: Record review of the available documentation indicated that the licensee did not have specific employee actions to be taken in the event of a fire or similar emergency located within the plan. Record review of the available documentation indicated that the licensee did not have fire protection procedures necessary for residents located within the plan. Record review of the available documentation indicated that the fire safety and evacuation plan	{0 810}		

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{0 810}	Continued From page 24 did not include 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. Record review of the available documentation indicated that employees did not receive training upon initial hire and twice per year thereafter on the facility fire safety and evacuation plan. The fire safety and evacuation plan was not available at all times and in a location known by all staff within the facility for the use of staff and occupants for guidance during an emergency. Record review of the available documentation indicated that the licensee did not provided training once per year to residents who are capable of self-evacuation on the proper actions to be taken in the event of a fire regarding movement, evacuation, and relocation. Record review of the available documentation did not indicate that evacuation drills had been conducted twice per year per shift and least once every other month as required. All deficiencies were verified by ED-N during the interview at approximately 10:30 a.m.	{0 810}		
0 900 SS=F	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of:	0 900		

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0 900	Continued From page 25 (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to execute a written assisted living contract with the required content for three of three residents (R2, R3, R7). 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	0 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24431	A. BUILDING: _____ B. WING _____	R 03/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCANDIA CAPITAL PARTNERS LLC	101 NORTH 58TH AVENUE WEST DULUTH, MN 55807

(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
0 900	Continued From page 26 of the residents). The findings include: R2 R2's diagnoses included hyperthyroidism, hyperlipidemia (high cholesterol), hypertension (HTN-high blood pressure), and congestive heart failure (CHF-condition in which the heart's function as a pump is inadequate to meet the body's needs). R2's service and care plans, dated September 1, 2022 and March 1, 2023 respectively, indicated services included: medication management (with four times daily medication administration), weekly showers with standby assist of 1 staff, monitoring of weight and blood pressure (BP), and treatment of compression stockings (TEDs) application and removal. On March 8, 2023, at 7:45 a.m., the evaluator observed unlicensed personnel (ULP)-J complete medication administration for R2. R2's record lacked an assisted living contract. R3 R3's diagnoses included CHF, HTN, presence of cardiac pacemaker, and presence of automatic implantable cardiac defibrillator. R3's record did not contain a service plan. R3's record lacked an assisted living contract. On March 8, 2023, at 6:57 a.m., the evaluator observed ULP-J complete medication administration for R3.	0 900		

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	24431	A. BUILDING: _____ B. WING _____	R 03/14/2023

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0 900	Continued From page 27 R7 R7's diagnosis included cerebral vascular accident (CVA) and atrial fibrillation. On March 8, 2023, at 9:00 a.m., the evaluator requested to R7's assisted living contract. The executive director (ED)-N provided a Rental Agreement dated November 9, 2013. R7's record lacked an assisted living contract. R2, R3 and R7's records lacked evidence that the contract had been fully executed as the facility must: - give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed; and - the facility must offer the resident the opportunity to identify a designated representative. On March 8, 2023, at 9:00 a.m., executive director (ED)-N stated a new contract had been developed to use, however it had not been issued to any resident or resident representative. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 900		
{01370} SS=E	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services	{01370}		

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	24431	A. BUILDING: _____ B. WING _____	R 03/14/2023

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{01370}	Continued From page 28 provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure two of two	{01370}		

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	24431	A. BUILDING: _____ B. WING _____	R 03/14/2023

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{01370}	Continued From page 29 unlicensed personnel (ULP) (ULP-B, ULP-M) received the required training/competency testing. 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: ULP-B ULP-B started employment January 23, 2021, and began providing direct care and assisted living services for the licensee's residents on August 1, 2021. On March 7, 2023, throughout the day, ULP-B was observed to provide direct care services to several residents. ULP-B's employee record lacked evidence of demonstrated competency in the following areas: - appropriate and safe techniques in personal hygiene and grooming, including*: (i) hair care and bathing*; (ii) care of teeth, gums, and oral prosthetic devices*; (iii) care and use of hearing aids*; and (iv) dressing and assisting with toileting*; - standby assistance techniques and how to perform them*; (Skill areas requiring demonstrated competency are denoted with *).	{01370}		

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	24431	A. BUILDING: _____ B. WING _____	R 03/14/2023

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{01370}	Continued From page 30 ULP-M ULP-M was hired to provide direct care services and assisted living services for the licensee's residents on January 17, 2023. R7's February 2023 medication administration record (MAR) indicated ULP-M administered medications to R7 on February 4, 5,6, and 7, 2023. ULP-M's employee record lacked evidence of demonstrated competency in the following areas: - appropriate and safe techniques in personal hygiene and grooming, including*: (i) hair care and bathing*; (ii) care of teeth, gums, and oral prosthetic devices*; (iii) care and use of hearing aids*; and (iv) dressing and assisting with toileting*; - standby assistance techniques and how to perform them*; (Skill areas requiring demonstrated competency are denoted with *). On March 7, 2023, at 2:00 p.m., executive director (ED)-N stated the registered nurse consultant (RNC)-O stated they had completed the above identified training, but they were unable to find the documentation pertaining to the training. The licensee's Staff Competency policy, dated August 1, 2021, indicated all residents will receive quality service delivered by staff who are educated and competent in the delivery of home care services. The policy indicated training and competency evaluations for all unlicensed personnel would include the items listed above and ULP may not work until they have	{01370}		

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	24431	A. BUILDING: _____ B. WING _____	R 03/14/2023

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{01370}	Continued From page 31 successfully passed the written competency and demonstration competency evaluations. No further information was provided.	{01370}		
{01380} SS=E	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure two of two unlicensed personnel (ULP) (ULP-B, ULP-M) received the required training/competency testing. 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	{01380}		

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	24431	A. BUILDING: _____ B. WING _____	R 03/14/2023

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SCANDIA CAPITAL PARTNERS LLC	101 NORTH 58TH AVENUE WEST DULUTH, MN 55807

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{01380}	Continued From page 32 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: ULP-B ULP-B started employment January 23, 2021, and began providing direct care and assisted living services for the licensee's residents on August 1, 2021. On March 7, 2023, throughout the day, ULP-B was observed to provide direct care services to several residents. ULP-B's employee record lacked evidence of demonstrated competency in the following areas: -observing, reporting and documenting of client status; -basic knowledge of body functioning and changes in body function injuries, or other observed changes that must be reported to appropriate personnel; -reading and recording temperature, pulse, and respirations of the resident*; -safe transfer techniques and ambulation *; and -range of motion and positioning*. (Skill areas requiring demonstrated competency are denoted with *) ULP-M ULP-M was hired to provide direct care services and assisted living services for the licensee's residents on January 17, 2023. R7's February 2023 medication administration record (MAR) indicated ULP-M administered	{01380}		

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	24431	A. BUILDING: _____ B. WING _____	R 03/14/2023

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{01380}	Continued From page 33 medications to R7 on February 4, 5,6, and 7, 2023. ULP-M's employee record lacked evidence of demonstrated competency in the following areas: -reading and recording temperature, pulse, and respirations of the resident*; -safe transfer techniques and ambulation *; and -range of motion and positioning*. (Skill areas requiring demonstrated competency are denoted with *) On March 7, 2023, at 2:00 p.m., executive director (ED)-N stated the registered nurse consultant (RNC)-O stated they had completed the above identified training, but they were unable to find the documentation pertaining to the training. The licensee's Staff Competency policy, dated August 1, 2021, indicated all residents will receive quality service delivered by staff who are educated and competent in the delivery of home care services. The policy indicated training and competency evaluations for all unlicensed personnel would include the items listed above and ULP may not work until they have successfully passed the written competency and demonstration competency evaluations. No further information was provided.	{01380}		
{01620} SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted	{01620}		

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{01620}	Continued From page 34 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 ensure a registered nurse (RN) conducted assessments with a uniform tool that included all required assessment area content for three of three residents (R2, R5, R9). 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:	{01620}		

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	24431	A. BUILDING: _____ B. WING _____	R 03/14/2023

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{01620}	Continued From page 35 R2 R2's diagnoses included hyperthyroidism, hyperlipidemia (high cholesterol), hypertension (HTN-high blood pressure), and congestive heart failure (CHF-condition in which the heart's function as a pump is inadequate to meet the body's needs). R2's 90 Day RN Comprehensive Assessment was completed February 10, 2023. On March 8, 2023, at 7:45 a.m., the evaluator observed unlicensed personnel (ULP)-J complete medication administration for R2. R2's 90 Day RN Comprehensive assessment form, dated February 10, 2023, lacked the following required assessment content: -the resident's personal lifestyle preferences, including: spiritual and cultural preferences; -risk indicators, including risk for dehydration, including history of urinary tract infections and current fluid intake pattern; and -elopement risk including history or previous elopements R5 R5's diagnosis included hypothyroidism, heart murmur, memory loss and chronic neck pain. R5's 90 Day RN Comprehensive Assessment was completed February 7, 2023. On March 8, 2023, at 6:52 a.m., the evaluator observed ULP-J complete medication administration for R2. R5's 90 Day RN Comprehensive assessment form, dated February 7, 2023, lacked the	{01620}		

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	24431	A. BUILDING: _____ B. WING _____	R 03/14/2023

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{01620}	Continued From page 36	{01620}		

following required assessment content:
-the resident's personal lifestyle preferences, including: sleep patterns, spiritual and cultural preferences; and
-risk indicators, including risk for dehydration, including history of urinary tract infections and current fluid intake pattern.

R9
R9's diagnoses included congested heart failure (CHF-condition in which the heart's function as a pump is inadequate to meet the body's needs), depression, and edema.

R9's 90 DAY RN Comprehensive Assessment was completed on February 7, 2023.

R5's 90 Day RN Comprehensive assessment form, dated February 7, 2023, lacked the following required assessment content:
-the resident's personal lifestyle preferences, including: sleep patterns, spiritual and cultural preferences; and
-risk indicators, including risk for dehydration, including history of urinary tract infections and current fluid intake pattern.

On March 8, 2023, at 9:00 a.m., registered nurse consultant (RNC)-O confirmed the above information was missing from the assessment tool used to reassess R2, R5, R9 and all residents receiving assisted living services by the licensee.

The licensee's Assessment - Comprehensive Services policy, dated August 1, 2021, indicated an individualized initial evaluation of all new clients shall be completed on admission by a registered nurse in order to develop a personalized service plan. The policy stated

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	24431	A. BUILDING: _____ B. WING _____	R 03/14/2023

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{01620}	Continued From page 37 ongoing client monitoring and reassessment must be conducted as needed based on changes in the needs of the client but cannot exceed 90 days from the last date of assessment. No further information was provided.	{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 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 a current written service plan was finalized no later than 14 calendar days after the date that services were	{01640}		

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	24431	A. BUILDING: _____ B. WING _____	R 03/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{01640}	Continued From page 38 first provided, for two of three residents (R9, R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R9 R9 was admitted on November 14, 2022, and received services under the licensee's assisted living with dementia care license. R9's diagnoses included congestive heart failure (CHF- condition in which the heart's function as a pump is inadequate to meet the body's needs), depression, and edema. R9's Care Plan dated March 2023, indicated R9 required total assist with bath/shower one day a week or more as needed (PRN), assist with dressing in the morning and evening, 1 staff to supervise/assist for safety in ambulation 10 times a day, and 1 staff to supervise/assist with toileting every 2 hours (10 times per day). R9's Medication Management Plan: Addendum to Service Plan, dated November 14, 2022, indicated R9 required assistance with medication administration. R9's Treatment Plan: Addendum to Service Plan, November 14, 2022, indicated R9 required	{01640}		

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	24431	A. BUILDING: _____ B. WING _____	R 03/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{01640}	Continued From page 39	{01640}		

assistance with compression stockings (TEDs), creams, and staff to set up C-pap [noninvasive ventilation breathing support through a face mask, nasal mask, or helmet].

On March 8, 2023, at 7:30 a.m., unlicensed personnel (ULP)-J stated she administered R9's morning medications.

R9's record lacked a service plan.

R5
R5 was admitted to the assisted living facility on September 1, 2020.

R5's diagnosis included hypothyroidism, heart murmur, memory loss and chronic neck pain.

R5's March 2023 care plan indicated services included: medication administration, assistance with bathing, grooming and dressing, and light housekeeping.

On March 8, 2023, at 6:52 a.m., the evaluator observed ULP-J complete medication administration for R5.

R5's record lacked a service plan.

On March 8, 2023, at 9:00 a. m., executive director (ED)-N stated they were unable to find a service plan for R9 and R5.

The licensee's Service Plans policy, dated May 9, 2019, indicated beginning with the initiation of services, a service plan was developed for the client based on an agreement with the client/responsible party and on the assessed needs identified in the comprehensive assessment. The service plan would be finalized

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24431	A. BUILDING: _____ B. WING _____	R 03/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{01640}	Continued From page 40 no later than 14 days after the initiation of services, if not already completed. No further information was provided.	{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 consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by:	{01650}		

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	24431	A. BUILDING: _____ B. WING _____	R 03/14/2023

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{01650}	Continued From page 41 Based on observation, interview and record review, the licensee failed to ensure the service plan included the required content for one of one resident (R2). This had the potential to affect all seven (7) residents who received services at the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2's diagnoses included hyperthyroidism, hyperlipidemia (high cholesterol), hypertension (HTN-high blood pressure), and congestive heart failure (CHF-condition in which the heart's function as a pump is inadequate to meet the body's needs). R2's service and care plans, dated September 1, 2022 and March 1, 2023 respectively, indicated services included: medication management (with four times daily medication administration), weekly showers with standby assist of 1 staff, monitoring of weight and blood pressure (BP), and treatment of compression stockings (TEDs) application and removal. On March 8, 2023, at 7:45 a.m., the evaluator observed unlicensed personnel (ULP)-J complete medication administration for R2. R2's Service Plan lacked the following required content:	{01650}		

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	24431	A. BUILDING: _____ B. WING _____	R 03/14/2023

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{01650}	Continued From page 42 - the method of monitoring staff providing services. On March 8, 2023, at 12:33 p.m., executive director (ED)-N stated R2's service plan was incomplete and did not include the above noted content. ED-N stated all service plans would be missing the above noted content. The licensee's Service Plans policy dated May 9, 2019, indicated the service plan included: -a description of the home care services to be provided; the service description may be in the form of the client's care plan developed with the client/responsible party; -the fees for services and the frequency of each service, according to the client's current review or assessment and client preferences; -the identification of the staff or categories of staff who would provide the services; -the schedule and methods of monitoring review of assessments of the client; -the frequency of sessions of supervision of staff and type of personnel who would supervise staff; and -a contingency plan. No further information was provided.	{01650}		
{01760} SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of	{01760}		

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	24431	A. BUILDING: _____ B. WING _____	R 03/14/2023

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{01760}	Continued From page 43 administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to administer medication as ordered by prescriber for one of four residents (R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R5's diagnosis included hypothyroidism, heart murmur, memory loss and chronic neck pain. R5's record lacked a service plan. R5's care plan, dated March 1, 2023, indicated services included medication administration. R5's prescriber orders, dated March 2, 2023, included estradiol cream 0.01% 2 grams applied topical every Wednesday for vaginal dryness. On March 8, 2023, at 6:52 a.m., the evaluator observed unlicensed personnel (ULP)-J complete	{01760}		

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	24431	A. BUILDING: _____ B. WING _____	R 03/14/2023

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{01760}	Continued From page 44 medication administration for R5. The evaluator reviewed R5's medication administration record (MAR) from February 1, 2023, through March 6, 2023, and noted the following opportunities estradiol cream was not administered: -two out of four opportunities in February -one out of one opportunity in March On March 7, 2023, at 3:55 p.m., registered nurse/consultant (RNC)-O confirmed R5's estradiol cream was not administered as indicated above. The licensee's Medication Documentation policy dated February 7, 2019, indicated if an administration of a medication was not completed staff will document the following: -the reason why the medication was not administered; -follow up procedure to meet the client's needs in compliance with the medication management plan; and -appropriate notification to the registered nurse (RN) supervisor or other persons as instructed regarding missed dosages No further information was provided.	{01760}		
{01790} SS=D	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days;	{01790}		

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	24431	A. BUILDING: _____ B. WING _____	R 03/14/2023

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{01790}	Continued From page 45 (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the	{01790}		

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{01790}	Continued From page 46 registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of two unlicensed personnel (ULP-B) was trained and had demonstrated competency to prepare and give medications for residents having unplanned time away. 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: ULP-B was hired on January 23, 2021, under the licensee's former comprehensive home care license and began providing assisted living services to the licensee's residents on August 1, 2021.	{01790}		

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{01790}	Continued From page 47 R9's February and March medication administration record (MAR) indicated ULP-B administered R9's morning medications on several occasions. ULP-B's employee record lacked evidence to indicate she had been trained and had demonstrated competency to provide medications to residents for unplanned times away from home. On March 8, 2023, at 9:00 a.m., executive director (ED)-N stated he was not able to find evidence ULP-B had completed the training as indicated above. The licensee's Medication Management Plan for Clients Away from Home dated February 7, 2019, indicated the registered nurse may delegate an ULP to set up the medications based on the following: -the ULP has documentation of passing a competency evaluation for medication administration; -the RN had instructed the ULP to ensure that all appropriate precautions were taken; and -the ULP may set up not more than a 72-hour supply of the client's medications. No further information was provided.	{01790}		
{01890} SS=E	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated	{01890}		

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{01890}	Continued From page 48 drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to date time-sensitive medications with an opened or expiration date for one of two residents (R7). In addition, the licensee failed to monitor for expired medication for two of two residents (R5, R7). 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). On November 7, 2023, at 3:55 p.m., the evaluator reviewed the medication cart with registered nurse consultant (RNC)-O confirming the following: TIME SENSITIVE MEDICATIONS R7 -opened ivrizia dry eye solution did not have a label which indicated the date the eye drop solution had been opened and when the solution would expire. EXPIRED MEDICATION R5's Estradrol Vaginal Cream expired August 2022. R7's artificial tears expired November 2022.	{01890}		

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	24431	A. BUILDING: _____ B. WING _____	R 03/14/2023

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{01890}	Continued From page 49 The manufacturer's instructions for ivnizia solution dated September 2021, directed to discard any unused solution after 90 days. The licensee's Storage/Control of Medications policy dated February 7, 2019, indicated medication is labeled completely and legibly. The medication label should contain the following: prescription number and name of medication, strength and quantity, expiration date for time-dated drugs, directions for use, resident's name, prescriber's name, date issues, and name and address of licensed pharmacy issuing the medication. No further information was provided.	{01890}		
{01950} SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions	{01950}		

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	24431	A. BUILDING: _____ B. WING _____	R 03/14/2023

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{01950}	Continued From page 50 in the resident's record; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure prior to delegating nursing tasks, the unlicensed personnel (ULP) were trained in the proper methods to perform the task or procedure for each resident, and were able to demonstrate the ability to competently follow the procedure to perform the tasks for one of one employees (ULP-B) with records reviewed. In addition, the licensee failed to ensure the registered nurse (RN) specified, in writing, specific instructions for treatments one of one residents (R9) reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: R9's diagnoses included congested heart failure (CHF-condition in which the heart's function as a pump is inadequate to meet the body's needs), depression, and edema. R9's prescriber's orders dated November 15, 2022, included compression (TED) stockings, compression wraps for right and left legs, size, large/short and CPAP (continuous positive airway pressure) machine, wear at night.	{01950}		

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	24431	A. BUILDING: _____ B. WING _____	R 03/14/2023

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{01950}	Continued From page 51 R9's Treatment Plan dated November 14, 2022, included TED socks, apply morning, remove evening and assist R9 with setting up the CPAP machine at night. R9's record lacked evidence the registered nurse (RN) had specified, in writing, specific instructions for the setup of R9's CPAP machine. On March 7, 2023, at 10:00 a.m., ULP-B stated she assisted R9 with the application of R9's TED stockings and setting up R9's CPAP machine. ULP-B's employee record lacked documentation to indicate ULP-B had been trained by the RN and demonstrated competency in the application of TED stockings and setting up R9's CPAP machine. On March 8, 2023, at 8:00 a.m., executive director (ED)-N stated he was not able to find documentation of ULP-B receiving training as indicated above. On March 8, 2023, at 10:00 a.m., licensed assisted living director (LALD)-L confirmed there were no written instructions pertaining to the setup of R9's CPAP machine. The licensee's Delegation of Assisted Living Services dated August 1, 2021, indicated the RN or other health professional may delegate procedures according to the following; -the RN instructed the home health aide in the proper methods to perform the procedure with respect to each client; -the RN provided the home health aide with written instructions specific to the client; -the home heath aide demonstrated to the RN competence in the procedure;	{01950}		

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	24431	A. BUILDING: _____ B. WING _____	R 03/14/2023

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{01950}	Continued From page 52 -the procedure is documented in the client's clinical record; and -the home health aide's competence is documented in his/her personnel file. No further information was provided.	{01950}		
{01960} SS=E	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure treatment or therapies were administered as directed and failed to document the reason they were not administered, and any follow up procedures provided to meet the resident's needs for two of three residents (R3, R9). 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	{01960}		

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	24431	A. BUILDING: _____ B. WING _____	R 03/14/2023

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{01960}	Continued From page 53 than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R3 R3's diagnoses included congestive heart failure (CHF-condition in which the heart's function as a pump is inadequate to meet the body's needs), HTN, presence of cardiac pacemaker, and presence of automatic implantable cardiac defibrillator. R3's prescriber's order dated December 22, 2022, included daily weights, if there is a gain/loss of two (2) pounds in one day or five pounds in a week, the Heart Center must be notified. R3's prescriber's orders dated March 2, 2023, included daily weights, if gain or loss of two (2) pounds in one day the Heart Center must be notified. R3's February 2023 Treatment Record included the following weights: -February 1, 2023, 140 pounds; -February 2, 2023, 142 pounds (two (2) pound increase); -February 3, 2023, 141 pounds; -February 4, 2023, 141 pounds; -February 5, 2023, 141 pounds; -February 6, 2023, 143 pounds (two (2) pound increase); -February 7, 2023, 143 pounds; -February 8, 2023, 141 pounds (two (2) pound decrease); -February 9, 2023, 143 pounds (two (2) pound increase);	{01960}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24431	A. BUILDING: _____ B. WING _____	R 03/14/2023

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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
{01960}	Continued From page 54 -February 10, 2023, 142 pounds; and -February 11, 2023, 141 pounds. R3's record lacked documentation to indicate the Heart Center was notified when R3's weights had a two (2) pound increase or decrease in weight. R9 R9's diagnoses included congested heart failure (CHF-condition in which the heart's function as a pump is inadequate to meet the body's needs), depression, and edema. R9's prescriber's orders dated November 15, 2022, included compression (TED) stockings, compression wraps for right and left legs, size, large/short and CPAP (continuous positive airway pressure) machine, wear at night. R9's Treatment Plan dated November 14, 2022, included TED socks, apply morning, remove evening and assist R9 with setting up the CPAP machine at night. On March 7, 2023, at 10:00 a.m., ULP-B stated she assisted R9 with the application of R9's TED stockings and setting up R9's CPAP machine. R9's record lacked documentation to indicate R9's were applied as ordered and ULP's assisted R9 with the setup of R9's CPAP machine. On March 8, 2023, at 11:00 a.m., licensed assisted living director (LALD)-L confirmed R3's record lacked evidence the Heart Center was notified when R3's weight increased or decreased by two (2) pounds as indicated above. LALD-L also confirmed R9's record lacked documentation pertaining to setting up R9's CPAP machine and TED stockings.	{01960}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24431	A. BUILDING: _____ B. WING _____	R 03/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCANDIA CAPITAL PARTNERS LLC	101 NORTH 58TH AVENUE WEST DULUTH, MN 55807

(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
{01960}	Continued From page 55 The licensee's Treatment and Therapy Management policy dated May 9, 2019, indicated the facility would use treatment and therapy protocols consistent with current evidence-based practice standards and guidelines. The registered nurse (RN) was responsible for assessing and developing the treatment and/or therapy service plan for clients. When the RN delegates treatments or therapies, the professional would monitor and evaluate its effectiveness on a regular basis as specified in the service plan. Each staff member who administers a treatment or therapy was responsible for documenting this in the clinical record. When a treatment or therapy was not administered as ordered or prescribed, staff would document the reason why it was not administered, and any follow-up procedures provided to meet the client's needs. No further information was provided.	{01960}		
{02040} SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced	{02040}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{02040}	Continued From page 56 by: Based on record review and interview, the licensee failed to provide a hazard vulnerability assessment or safety risk assessment of the physical environment on and around the property. This deficient practice had the ability to affect all staff, residents, 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). Findings include: A record review of available documentation and interview were conducted March 14, 2023, at approximately 10:00 a.m. with executive director (ED)-N on the hazard vulnerability assessment for the physical environment of the facility. Record review of the available documentation indicated that the licensee had not performed a hazard vulnerability assessment with mitigation factors on and around the property. This deficient condition was verified by ED-N during the interview at approximately 10:30 a.m.	{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	{02110}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24431	A. BUILDING: _____ B. WING _____	R 03/14/2023

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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
{02110}	Continued From page 57 procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure policies and procedures required in the licensing of assisted living facilities with dementia care were developed or implemented, and provided to each resident	{02110}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{02110}	Continued From page 58 and/or the resident's legal and designated representative at the time of move-in. This had the potential to affect all dementia care 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: The licensee held an Assisted Living with Dementia Care license issued August 1, 2022. The licensee lacked evidence the following required policies and procedures related to dementia care had been developed or provided to residents, their legal representatives and designated representatives at time of move in: -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; -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	{02110}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{02110}	Continued From page 59 only; -transportation coordination and assistance to and from outside medical appointments; and -safekeeping of residents' possessions. On March 7, 2023, at 10:10 a.m., licensed assisted living director (LALD)-L stated they have ordered the dementia care policies but have not been individualized to the facility or given to residents and/or the resident's legal and designated representative. No further information was provided.	{02110}		
{02170} SS=F	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to:	{02170}		

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{02170}	Continued From page 60 (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to conduct an evaluation for activities that addressed all provisions and failed to develop an individualized activity plan with required content based on the evaluation, for three of three residents (R2, R5, R9) who received services under an assisted living with dementia care license. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2 R2's diagnoses included hyperthyroidism, hyperlipidemia (high cholesterol), hypertension	{02170}		

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{02170}	Continued From page 61 (HTN-high blood pressure), and congestive heart failure (CHF-condition in which the heart's function as a pump is inadequate to meet the body's needs). R2's Dementia Activity Assessment tool, dated February 10, 2023, indicated R2 was evaluated for the following activities: - past and current interests - current abilities and skills - emotional and social needs and patterns - physical abilities and limitations - adaptations necessary for the resident to participate; and - identification of activities for behavioral interventions On March 8, 2023, at 7:45 a.m., the evaluator observed unlicensed personnel (ULP)-J complete medication administration for R2. R2's record lacked the development of an individualized activity plan. R5 R5's diagnosis included hypothyroidism, heart murmur, memory loss and chronic neck pain. R5's Dementia Activity Assessment tool, dated February 7, 2023, indicated R5 was evaluated for the following activities: - past and current interests; - past skills/abilities; - physical abilities and limitations; -social needs; -adaptations needed for participation; and -behavioral interventions On March 8, 2023, at 6:52 a.m., the evaluator observed ULP-J complete medication	{02170}		

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	24431	A. BUILDING: _____ B. WING _____	R 03/14/2023

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{02170}	Continued From page 62 administration for R5. R5's record lacked evidence the resident had been evaluated for activities according to the licensing rules of the facility, to include the following: - current abilities and skills; and - emotional needs In addition, R5's record lacked the development of an individualized activity plan. R9 R9's diagnoses included CHF, depression, and edema. R9's Dementia Activity Assessment tool, dated February 7, 2023, indicated R9 was evaluated for the following activities: - past and current interests - current abilities and skills - emotional and social needs and patterns - physical abilities and limitations - adaptations necessary for the resident to participate; and - identification of activities for behavioral interventions On March 8, 2023, at 7:06 a.m., the evaluator observed ULP-J complete medication administration for R9. R9's record lacked the development of an individualized activity plan. On March 8, 2023, at 12:30 p.m., executive director (ED)-N stated R2, R5 and R9's record lacked the development of an individualized activity plan.	{02170}		

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{02170}	Continued From page 63 No further information was provided.	{02170}		

Minnesota Department of Health
Minnesota Department of Health
PO Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *03/07/23*
Time: 10:30:00
Report: 8010231041

Food and Beverage Establishment Inspection Report

Location:
Scandia Capital Partners Llc
101 North 58th Avenue West
Duluth, MN55807
St. Louis County, 69

Establishment Info:
ID #: 0037767
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 6513351586
ID #:

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

The following orders previously issued on 11/21/22 have NOT been corrected.

4-300 Equipment Numbers and Capacities

4-302.12B ** Priority 2 **

MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.

THERE WAS NOT A THIN SMALL DIAMETER PROBE FOOD THERMOMETER ON SITE.

Issued on: 11/21/22 *Comply By: 12/01/22*

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Chlorine: = 100 PPM at Degrees Fahrenheit
Location: SPRAY BOTTLE
Violation Issued: No

Hot Water: = at Degrees Fahrenheit
Location: DISHWASHER SANITIZING CYCLE-TEMP TAPE TURNED BLACK
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Upright Cooler
Temperature: 41 Degrees Fahrenheit - Location: MILK-GE
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 41 Degrees Fahrenheit - Location: OLIVES-GE
Violation Issued: No

Type: Full
Date: *03/07/23*
Time: 10:30:00
Report: 8010231041
Scandia Capital Partners Llc

Food and Beverage Establishment Inspection Report

Process/Item: Upright Cooler
Temperature: 41 Degrees Fahrenheit - Location: MILK-AMANA
Violation Issued: No

Process/Item: Upright Freezer
Temperature: Degrees Fahrenheit - Location: FOODS FROZEN- GE
Violation Issued: No

Process/Item: Upright Freezer
Temperature: Degrees Fahrenheit - Location: FOODS FROZEN-FRIGIDAIRE
Violation Issued: No

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

COMMENTS:

THIS WAS A FOLLOW UP INSPECTION OF THE INSPECTION DONE ON 11/21/2022.

THREE OF THE FOUR ORDERS HAVE BEEN CORRECTED.

ANOTHER THIN SMALL DIAMETER PROBE THERMOMETER WILL BE ORDERED TO USE AT THIS SITE.

THE USE OF RAW EGGS ARE ONLY TO BE USED IN ONE RESIDENT'S SERVING AT A SINGLE MEAL IF THE EGGS ARE COMBINED, COOKED AND SERVED IMMEDIATELY OR IN BAKED GOODS THAT ARE THOROUGHLY COOKED IF EGGS ARE COMBINED AS AN INGREDIENT IMMEDIATELY BEFORE BAKING.

PASTEURIZED EGGS OR EGG PRODUCTS MUST BE SUBSTITUTED FOR RAW EGGS WHEN MORE THAN ONE EGG IS BROKEN, COMBINED AND NOT COOKED, BAKED, OR USED IMMEDIATELY.

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 8010231041 of 03/07/23.

Certified Food Protection Manager: Morgan Michelle Brandt

Certification Number: FM106125 Expires: 04/20/24

Inspection report reviewed with person in charge and emailed.

Signed: _____ Signed: _____

Morgan Brandt
CFPM

8010

651-201-4500
health.foodlodging@state.mn.us

Report #: 8010231041

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Minnesota Department of Health
PO Box 64975
St. Paul, MN 55164-0975

No. of RF/PHI Categories Out	0	Date	03/07/23
No. of Repeat RF/PHI Categories Out	0	Time In	10:30:00
Legal Authority MN Rules Chapter 4626		Time Out	

	Address	City/State	Zip Code	Telephone
Scandia Capital Partners Llc	101 North 58th Avenue West	Duluth, MN	55807	6513351586

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
0037767		Full		

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
Supervision							
1	(IN)	OUT			PIC knowledgeable; duties & oversight		
2	(IN)	OUT	N/A		Certified food protection manager, duties		
Employee Health							
3	(IN)	OUT			Mgmt/Staff;knowledge,responsibilities&reporting		
4	(IN)	OUT			Proper use of reporting, restriction & exclusion		
5	(IN)	OUT			Procedures for responding to vomiting & diarrheal events		
Good Hygenic Practices							
6	(IN)	OUT		N/O	Proper eating, tasting, drinking, or tobacco use		
7	(IN)	OUT		N/O	No discharge from eyes, nose, & mouth		
Preventing Contamination by Hands							
8	(IN)	OUT		N/O	Hands clean & properly washed		
9	IN	OUT	N/A	(N/O)	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10	(IN)	OUT			Adequate handwashing sinks supplied/accessible		
Approved Source							
11	(IN)	OUT			Food obtained from approved source		
12	IN	OUT	N/A	(N/O)	Food received at proper temperature		
13	(IN)	OUT			Food in good condition, safe, & unadulterated		
14	IN	OUT	(N/A)	N/O	Required records available; shellstock tags, parasite destruction		
Protection from Contamination							
15	(IN)	OUT	N/A	N/O	Food separated and protected		
16	(IN)	OUT	N/A		Food contact surfaces: cleaned & sanitized		
17	(IN)	OUT			Proper disposition of returned, previously served, reconditioned, & unsafe food		

	Compliance Status					COS	R
Time/Temperature Control for Safety							
18	IN	OUT	N/A	(N/O)	Proper cooking time & temperature		
19	IN	OUT	(N/A)	N/O	Proper reheating procedures for hot holding		
20	IN	OUT	N/A	(N/O)	Proper cooling time & temperature		
21	IN	OUT	N/A	(N/O)	Proper hot holding temperatures		
22	(IN)	OUT	N/A		Proper cold holding temperatures		
23	(IN)	OUT	N/A	N/O	Proper date marking & disposition		
24	IN	OUT	(N/A)	N/O	Time 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)	OUT	N/A		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)	OUT			Toxic 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

						COS	R
Safe Food and Water							
30	IN	OUT	(N/A)		Pasteurized eggs used where required		
31					Water & ice obtained from an approved source		
32	IN	OUT	(N/A)		Variance obtained for specialized processing methods		
Food Temperature Control							
33					Proper cooling methods used; adequate equipment for temperature control		
34	IN	OUT	N/A	(N/O)	Plant food properly cooked for hot holding		
35	IN	OUT	N/A	(N/O)	Approved thawing methods used		
36	X				Thermometers provided & accurate		X
Food Identification							
37					Food properly labled; original container		
Prevention of Food Contamination							
38					Insects, rodents, & animals not present		
39					Contamination prevented during food prep, storage & display		
40					Personal cleanliness		
41					Wiping cloths: properly used & stored		
42					Washing fruits & vegetables		

			COS	R
Proper Use of Utensils				
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
Utensil Equipment and Vending				
47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48		Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
Physical Facilities				
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 03/08/23

Inspector (Signature)

Electronically Delivered

February 14, 2023

Licensee
Scandia Capital Partners LLC
101 North 58th Avenue West
Duluth, MN 55807

RE: Project Number(s) SL24431015

Dear Licensee:

On February 2, 2023, February 4, 2023, and February 5, 2023, the Minnesota Department of Health completed a monitoring visit of your facility to assess the progress of Scandia Capital Partners LLC to correct the violations cited during the evaluation on November 23, 2022, and during the monitoring visit completed December 30, 2022.

At this time, the monitoring visit was focused on tag orders 0110, 0340, 0470, 0495, 1290 and 1750.

This monitoring visit found your facility is not correcting all of the state licensing orders issued pursuant to the November 23, 2022, evaluation and the December 30, 2022, monitoring visit.

As a result of the monitoring visit and in accordance with Minn. Stat. § 144G.31 Subd. 4 (a), the reissued tags subject to immediate penalty assessment are as follows:

0340-Correction Orders-144g.30 Subd. 5 - $3,000.00

0470-Minimum Requirements-144g.41 Subdivision 1 - $3,000.00

0495-Minimum Requirements-144g.41 Subd. 1 (14)- $3,000.00

1750-Delegation Of Medication Administration-144g.71 Subd. 7 - $3,000.00

The details of the violations noted at the time of this monitoring evaluation completed on February 5, 2023 (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.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $12,000.00**. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), by the correction order date, the licensee must document in the provider's records any action taken to comply with the correction order by the correction order date. The commissioner may request a copy of this documentation and the assisted living facility's action to respond to the correction orders in future evaluations, upon a complaint investigation, and as otherwise needed.

IMPOSITION OF FINES:

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

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you have one opportunity to challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. This written request must be received by the Department of Health within 15 calendar days of the correction order receipt date. Please send your written request via email to the following:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970
Health.HRD.Appeals@state.mn.us

REQUESTING A HEARING

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

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

All conditions noted in the Conditional Order effective on December 20, 2022, will remain in effect through the conditional license period.

We urge you to review these orders carefully. If you have questions, please contact Jessica Chenze at 218-332-5175.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Sincerely,

Jessica Chenze, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jessica.chenze@state.mn.us
Telephone: | Fax: 218-332-5196

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24431	A. BUILDING: _____ B. WING _____	R 02/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCANDIA CAPITAL PARTNERS LLC	101 NORTH 58TH AVENUE WEST DULUTH, MN 55807

(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: Project SL24431015-2 On February 2, 2023, February 4, 2023, and February 5, 2023, the Minnesota Department of Health conducted monitoring visit with the above provider to follow-up on orders issued pursuant to a survey completed on November 23, 2022. At this time, the monitoring visit was focused on tag orders 0110, 0340, 0470, 0495, 1290 and 1750. As a result of the monitoring visit, the following orders were reissued. Immediate correction orders were identified on February 2, 2023, and issued and/or reissued for SL24431015-2, tag identification 0470, 0495, and 1750. On February 6, 2023, the immediacy of correction orders 0470, 0495, and 1750 was removed, however non-compliance remained at a scope and level of I.	{0 000}	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	

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{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 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; (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:	{0 250}		
{0 340} SS=I	144G.30 Subd. 5 Correction orders (a) A correction order may be issued whenever the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, or an employee of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail or e-mail copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must document in the facility's records any action taken	{0 340}		

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{0 340}	Continued From page 3 to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to have sufficient documentation with actions taken to comply with immediate order, tag identification 0470, 0495, and 1750, during a survey completed on November 23, 2023. 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 November 23, 2022, the Minnesota Department of Health completed a survey resulting in 31 correction order and immediate orders 0110, 0470, 0495, 1290, 1750 and 2310. On December 30, 2022, the Minnesota Department of Health completed a monitoring communication with the licensee. The licensee failed to provide sufficient documentation with actions taken to comply with the immediate order tag identifications 0110 and 0495, as well as required outlined in the letter of Notice of	{0 340}		

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{0 340}	Continued From page 4 Conditional License. During a monitoring visit on February 2, 2023, the evaluator conducted observations, reviewed resident and employee records, interviewed owner/agent (O/A)-E, registered nurse (RN)-K, unlicensed personnel (ULP)-B, community coordinator (CC)-A, and communicated via email with licensed assisted living director (LALD)-L. The licensee lacked evidence to indicate 0340, 0470, 0495, and 1750 issued on November 23, 2022, were corrected. No further information was provided.	{0 340}		
{0 470} SS=I	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the	{0 470}		

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{0 470}	Continued From page 5 facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensue one direct care staff was available 24 hours a day, seven days a week who were responsible for responding to requests of residents for assistance. This has a potential to affect all residents. 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. This resulted in a reissued immediate correction order on February 2, 2023. The findings include: The licensee has assisted living with dementia care license. On February 2, 2023, at 9:00 a.m., the evaluator observed one unlicensed personnel (ULP) providing direct care services to the nine (9) residents. On February 2, 2023, at 10:03 a.m., the evaluator observed ULP-B wheel a resident outside in a wheelchair and assist the resident into the waiting van, to transport the resident to a medical appointment. ULP-B left the other eight (8) residents in the facility without staff in the building to respond to requests of residents for	{0 470}		

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{0 470}	Continued From page 6 assistance. ULP-B stated she should have not left the building unattended, but she had no other choice. The facilities resident roster dated November 21, 2022, indicated residents required assistance with medication administration, and had falls in the last three months. No further information provided. On February 6, 2023, the immededicacy was removed as confirmed by supervisor evaluation, however, noncompliance remains at a scope and level of three, widespread (I).	{0 470}		
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by:	{0 480}		

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{0 495}	Continued From page 7	{0 495}		
{0 495} SS=I	144G.41 Subd. 1 (14) Minimum Requirements (14) provide staff access to an on-call registered nurse 24 hours per day, seven days per week. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure that a registered nurse (RN) was available on-call 24 hours a day, seven days per week. This had the potential to affect all seven (7) residents and staff of the facility. 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). This resulted in a reissued immediate correction order on February 2, 2023. The findings include: On February 2, 2023, at 9:00 a.m., unlicensed personnel (ULP)-B stated the licensee hired RN-K one day last week. ULP-B stated RN-K had two other jobs. ULP-B stated when ULP-B worked last there was a letter posted on the bulletin board stating RN-K was on call 24/7 and her phone number. Today when ULP-B came to work, the letter was not posted on the bulletin board. ULP-B had a copy of the letter her phone and ULP-B texted a copy of the letter to the evaluator.	{0 495}		

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{0 495}	Continued From page 8 On February 2, 2023, at 10:03 a.m., the evaluator called RN-K's phone. RN-K did not answer the phone. The evaluator left a message for RN-K to return the call. On February 2, 2023, at 10:56 a.m., owner/agent (O/A)-E called the evaluator. O/A-E stated RN-K was working part time because she has another job in the morning and is unavailable. O/A-E stated RN-K was working at all three facilities in the Duluth location. O/A-E stated they had also hired another RN who would be starting in a few weeks because she needs to give notice to her current employer. O/A-E stated this RN would be working full time for the three sites in Duluth and would be starting no later than February 27, 2023. On February 2, 2023, at 11:38 a.m., RN-K called the evaluator. RN-K stated she was not on call 24/7 for the facilities. RN-K stated she had been on site about a half hour on February 1, 2023. Because there was no equipment (computer) for her use, RN-K left. RN-K stated on February 1, 2023, RN-K emailed the licensed assisted living director (LALD)-L stating that she was resigning as of today. RN-K stated she never received any orientation and had been told that she was only there to update care plans. RN-K stated O/A-E called her this morning and asked her why she was resigning. RN-J stated she told O/A-E that she valued her license, and she was not going to put her license on the line. No further information was provided. On February 6, 2023, the immedediacy was removed as confirmed by supervisor evaluation, however, noncompliance remains at a scope and level of three, widespread (I).	{0 495}		

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{0 510} SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by:	{0 510}		
{0 550} SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by:	{0 550}		

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{0 580}	Continued From page 10	{0 580}		
{0 580} SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by:	{0 580}		
{0 630} SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by:	{0 630}		

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{0 630}	Continued From page 11	{0 630}		
{0 640} SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by:	{0 640}		
{0 660} SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of	{0 660}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24431	A. BUILDING: _____ B. WING _____	R 02/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{0 660}	Continued From page 12 the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by:	{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 all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced	{0 680}		

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	24431	A. BUILDING: _____ B. WING _____	R 02/05/2023

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{0 680}	Continued From page 13 by:	{0 680}		
{0 730} SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional;	{0 730}		

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	24431	A. BUILDING: _____ B. WING _____	R 02/05/2023

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{0 730}	Continued From page 14 (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by:	{0 730}		
{0 790} SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by:	{0 790}		

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	24431	A. BUILDING: _____ B. WING _____	R 02/05/2023

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{0 800}	Continued From page 15	{0 800}		
{0 800} SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by:	{0 800}		
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in	{0 810}		

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	24431	A. BUILDING: _____ B. WING _____	R 02/05/2023

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{0 810}	Continued From page 16 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:	{0 810}		
{0 940} SS=C	144G.50 Subd. 2 (e; 5-7) Contract information (5) a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: (i) whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; (ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); (iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; (iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required;	{0 940}		

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	24431	A. BUILDING: _____ B. WING _____	R 02/05/2023

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{0 940}	Continued From page 17 (v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; (vi) a statement that residents may be eligible for assistance with rent through the housing support program; and (vii) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; (6) the contact information to obtain long-term care consulting services under section 256B.0911; and (7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by:	{0 940}		
{0 950} SS=E	144.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your	{0 950}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24431	A. BUILDING: _____ B. WING _____	R 02/05/2023

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{0 950}	Continued From page 18 guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by:	{0 950}		
{0 970} SS=C	144.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by:	{0 970}		
{01370} SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all	{01370}		

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	24431	A. BUILDING: _____ B. WING _____	R 02/05/2023

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{01370}	Continued From page 19 unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by:	{01370}		

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	24431	A. BUILDING: _____ B. WING _____	R 02/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{01370}	Continued From page 20	{01370}		
{01380} SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by:	{01380}		
{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;	{01470}		

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	24431	A. BUILDING: _____ B. WING _____	R 02/05/2023

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{01470}	Continued From page 21 (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 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	{01470}		

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	24431	A. BUILDING: _____ B. WING _____	R 02/05/2023

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{01470}	Continued From page 22 (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:	{01470}		
{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:	{01540}		
{01620} SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring	{01620}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24431	A. BUILDING: _____ B. WING _____	R 02/05/2023

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{01620}	Continued From page 23 (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:	{01620}		
{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	{01640}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{01640}	Continued From page 24 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. (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:	{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;	{01650}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{01650}	Continued From page 25 (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:	{01650}		
{01750} SS=I	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure competence	{01750}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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SCANDIA CAPITAL PARTNERS LLC	101 NORTH 58TH AVENUE WEST DULUTH, MN 55807

(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
{01750}	Continued From page 26 prior to delegating the nursing task of medication administration, for one of one unlicensed personnel (ULP-M) demonstrated competency for administering medications. This had a potential affect all residents. 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). This resulted in a immediate correction order on February 2, 2023. The findings include: On February 2, 2023, at 9:00 a.m., ULP-B stated ULP-M (a new ULP) worked on February 1, 2022, (not sure time she started) until February 2, 2023, at 6:00 a.m. ULP-B thought another ULP worked with ULP-M until around 6:00 p.m. On February 2, 2023, at 12:00 p.m. community coordinator (CC)-A stated she worked with ULP-M February 1, 2022, until she left at around 10:00 p.m., and ULP-M was the only ULP working from 10:00 p.m. until 6:00 a.m. on February 2, 2023. R8's February 2023, Medication Administration Record (MAR) contained a prescriber's order for acetaminophen (pain relief) 500 mg (milligrams) one tablet orally every four (4) to six (6) hours as needed.	{01750}		

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{01750}	Continued From page 27 On February 2, 2023, at 11:26 a.m., the evaluator emailed the licensed assisted living director (LALD)-D and owner/agent (O/A)-E requesting documentation of ULP-M's training ULP-M had received. At 11:50 a.m., the evaluator received a email from LALD-D indicated ULP-M is in her orientation period and has not had her competencies done. Those are scheduled next Wednesday and the [name of consulting agency] will be completing those. No further information was provided. TIME PERIOD OF CORRECTION: IMMEDIATE On February 6, 2023, the immedediacy was removed as confirmed by supervisor evaluation, however, noncompliance remains at a scope and level of three, widespread (I).	{01750}		
{01760} SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced	{01760}		

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{01760}	Continued From page 28 by:	{01760}		
{01790} SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled;	{01790}		

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{01790}	Continued From page 29 (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by:	{01790}		
{01880} SS=D	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by:	{01880}		

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{01880}	Continued From page 30	{01880}		
{01890} SS=E	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by:	{01890}		
{01910} SS=E	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition.	{01910}		

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{01910}	Continued From page 31 This MN Requirement is not met as evidenced by:	{01910}		
{01950} SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by:	{01950}		
{01960} SS=E	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident	{01960}		

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{01960}	Continued From page 32 record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by:	{01960}		
{02040} SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by:	{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	{02110}		

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{02110}	Continued From page 33 must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (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:	{02110}		

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{02170}	Continued From page 34	{02170}		
{02170} SS=D	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities.	{02170}		

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{02170}	Continued From page 35 This MN Requirement is not met as evidenced by:	{02170}		
{02310} SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by:	{02310}		
{03090} SS=C	144.6502, Subd. 8 Notice to Visitors Subd. 8.Notice to visitors. (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by:	{03090}		

Electronically Delivered

December 30, 2022

Licensee
Scandia Capital Partners, LLC
101 North 58th Avenue West
Duluth, MN 55807

RE: Project Number(s) SL24431015

Dear Licensee:

On December 30, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine correction of orders found on the evaluation completed on November 23, 2022. This follow-up evaluation determined your facility had not corrected all of the state licensing orders issued pursuant to the November 23, 2022 evaluation.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state licensing orders issued pursuant to the last evaluation completed on November 23, 2022, found not corrected at the time of the December 30, 2022, follow-up evaluation and/or subject to penalty assessment are as follows:

0340-Correction Orders-144g.30 Subd. 5 = $3,000

The details of the violations noted at the time of this follow-up evaluation completed on December 30, 2022 (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.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,000**. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), by the correction order date, the licensee must document in the provider's records any action taken to comply with the correction order by the correction order date. The commissioner may request a copy of this documentation and the assisted living facility's action to respond to the correction orders in future evaluations, upon a complaint investigation, and as otherwise needed.

IMPOSITION OF FINES:

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

authorized in §144G.20.

Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in §144G.20.

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you have one opportunity to challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. This written request must be received by the Department of Health within 15 calendar days of the correction order receipt date. Please send your written request via email to the following:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970
Health.HRD.Appeals@state.mn.us

REQUESTING A HEARING

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

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

We urge you to review these orders carefully. If you have questions, please contact Jessie Chenze at 218-332-5175.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Sincerely,

Jessie Chenze, RN, BSN
Supervisor 1 | State Evaluations Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Office: 218-332-5175 | Fax: 218-332-5196

PMB

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{0 000}	Initial Comments 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: Project SL24431015-1 On December 23, 2022, through December 30, 2022, the Minnesota Department of Health conducted monitoring correspondence with the above provider to follow-up on orders issued pursuant to a survey completed on November 23, 2022. At this time, the monitoring correspondence was focused on tag order identification 0340 and requirements of conditional license. As a result of the communicaitons, the following orders were reissued.	{0 000}	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
{0 110} SS=I	144G.10 Subdivision 1a Assisted living director license required	{0 110}		

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{0 110}	Continued From page 1 Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by:	{0 110}		
{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 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;	{0 250}		

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{0 250}	Continued From page 2 (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4; (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 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:	{0 250}		
{0 340} SS=I	144G.30 Subd. 5 Correction orders (a) A correction order may be issued whenever the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, or an employee of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction.	{0 340}		

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	24431	A. BUILDING: _____ B. WING _____	R 12/30/2022

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{0 340}	Continued From page 3 (b) The commissioner shall mail or e-mail copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide sufficient documentation with actions taken to comply with the immediate order tag identifications 0110 and 0470, as well as requirements outlined in the letter of Notice of Conditional License, during monitoring communication completed on December 30, 2022. 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:	{0 340}		

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{0 340}	Continued From page 4 On December 20, 2022, Minnesota Department of Health (MDH) emailed a Notice of Conditional License letter to the licensee, outlining requirements the licensee must take, including: -Fill vacant positions: Scandia Capital Partners LLC must fill the vacant Assisted Living Director and Clinical Nurse Supervisor positions with appropriately licensed individuals by December 27, 2022. -Consultant: Scandia Capital Partners LLC will contract with an RN (registered nurse) to provide consultation concerning all resident(s) to whom Scandia Capital Partners LLC provides licensed assisted living services under the conditional license. On December 23, 2022, at 9:00 a.m., MDH State Evaluations supervisors and management members held an informal conference with owner/agent (O/A)-E, regional director/licensed practical nurse (RD/LPN)-D, and assistant regional director (ARD)-H. MDH outlined expectations and concerns during the informal conference. O/A-E, RD/LPN-D, and ARD-H verbalized understanding of expectations, including filling of vacant positions. RD/LPN-D stated she was a licensed assisted living director (LALD) and would begin to work on establishing herself as the facility's LALD that day. O/A-E and RD/LPN-D confirmed an RN had been hired, although could not begin employment until January 3, 2023. On December 27, 2022, as of 4:00 p.m., the Board of Executives for Long-Term Services and Supports (BELTSS) website did not indicate RD/LPN-D to be the director of record for the licensee.	{0 340}		

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{0 340}	Continued From page 5 On December 28, 2022, at 11:02 a.m., evaluation supervisor attempted to call RD/LPN-D, however, the voice mailbox was full. On December 28, 2022, at 11:24 a.m., evaluation supervisor emailed RD/LPN-D and O/A-E to inquire as to the status of filling the vacant positions and hiring an RN consultant. At 11:30 a.m., O/A-E responded RD/LPN-D would be the LALD, an RN was hired, and an RN consultant had been retained. On December 28, 2022, at 12:55 p.m., evaluation supervisor inquired via email if RD/LPN-D had established herself as director of record with BELTSS, what the starting date was for the RN, and the plan for the required interim coverage needed. On December 28, 2022, at 1:06 p.m., evaluation supervisor emailed RN consultant to inquire about receiving a resume. On December 28, 2022, at 1:45 p.m., RD/LPN-D indicated she had not yet reached out to BELTSS to establish herself as the facility LALD. RD/LPN-D additionally indicated the RN would not be starting employment until January 3, 2023, and RD/LPN-D would be the backup plan for nursing coverage until then. On December 28, 2022, at 1:53 p.m., evaluation supervisor received an email from the RN consultant agency, indicating an RN consultant had not yet been assigned, as the agency was waiting to learn the expectations of on-site time. Evaluation supervisor responded that MDH's expectations would include periodic on-site visits. On December 30, 2022, at 8:15 a.m., evaluation	{0 340}		

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{0 340}	Continued From page 6 supervisor emailed RD/LPN-D and O/A-E inquiring if they completed the requirements with BELTSS, and for the name of the specific RN consultant the licensee had retained. At 8:45 a.m., RD/LPN-D responded via email she would work with BELTSS on Monday (January 2, 2023) and requested O/A-E to provide information on the RN consultant. No further information was provided.	{0 340}		
{0 470} SS=I	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the	{0 470}		

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{0 470}	Continued From page 7 appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by:	{0 470}		
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by:	{0 480}		
{0 495} SS=I	144G.41 Subd. 1 (14) Minimum Requirements (14) provide staff access to an on-call registered nurse 24 hours per day, seven days per week. This MN Requirement is not met as evidenced	{0 495}		

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{0 495}	Continued From page 8 by:	{0 495}		
{0 510} SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by:	{0 510}		
{0 550} SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center.	{0 550}		

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{0 550}	Continued From page 9 This MN Requirement is not met as evidenced by:	{0 550}		
{0 580} SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by:	{0 580}		
{0 630} SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes	{0 630}		

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{0 630}	Continued From page 10 self-abuse. This MN Requirement is not met as evidenced by:	{0 630}		
{0 640} SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by:	{0 640}		
{0 660} SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that	{0 660}		

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{0 660}	Continued From page 11 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:	{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 all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site.	{0 680}		

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{0 680}	Continued From page 12 (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by:	{0 680}		
{0 730} SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the	{0 730}		

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{0 730}	Continued From page 13 resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by:	{0 730}		
{0 790} SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by:	{0 790}		

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{0 790}	Continued From page 14	{0 790}		
{0 800} SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by:	{0 800}		
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be	{0 810}		

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{0 810}	Continued From page 15 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:	{0 810}		
{0 940} SS=C	144G.50 Subd. 2 (e; 5-7) Contract information (5) a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: (i) whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; (ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); (iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; (iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the	{0 940}		

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{0 940}	Continued From page 16 housing support program, and if so, the length of time that private payment is required; (v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; (vi) a statement that residents may be eligible for assistance with rent through the housing support program; and (vii) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; (6) the contact information to obtain long-term care consulting services under section 256B.0911; and (7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by:	{0 940}		
{0 950} SS=E	144.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and	{0 950}		

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	24431	A. BUILDING: _____ B. WING _____	R 12/30/2022

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{0 950}	Continued From page 17 advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by:	{0 950}		
{0 970} SS=C	144.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by:	{0 970}		
{01290} SS=I	144G.60 Subdivision 1 Background studies required	{01290}		

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{01290}	Continued From page 18 (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by:	{01290}		
{01370} SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices;	{01370}		

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{01370}	Continued From page 19 (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by:	{01370}		
{01380} SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to	{01380}		

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{01380}	Continued From page 20 appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by:	{01380}		
{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	{01470}		

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{01470}	Continued From page 21 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 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:	{01470}		
{01540} SS=D	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED	{01540}		

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{01540}	Continued From page 22 (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:	{01540}		
{01620} SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted 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	{01620}		

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{01620}	Continued From page 23 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:	{01620}		
{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. (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}		

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{01640}	Continued From page 24 when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by:	{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 consistent with chapters 145B and 145C, and declarations made by the resident under those	{01650}		

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{01650}	Continued From page 25 chapters. This MN Requirement is not met as evidenced by:	{01650}		
{01750} SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by:	{01750}		
{01760} SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any	{01760}		

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{01760}	Continued From page 26 follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by:	{01760}		
{01790} SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must	{01790}		

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{01790}	Continued From page 27 address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by:	{01790}		
{01880} SS=D	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and	{01880}		

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{01880}	Continued From page 28 substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by:	{01880}		
{01890} SS=E	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by:	{01890}		
{01910} SS=E	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in	{01910}		

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{01910}	Continued From page 29 the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by:	{01910}		
{01950} SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by:	{01950}		

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{01960} SS=E	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by:	{01960}		
{02040} SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by:	{02040}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24431	A. BUILDING: _____ B. WING _____	R 12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCANDIA CAPITAL PARTNERS LLC	101 NORTH 58TH AVENUE WEST DULUTH, MN 55807

(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
{02110}	Continued From page 31	{02110}		
{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 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.	{02110}		

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{02110}	Continued From page 32 This MN Requirement is not met as evidenced by:	{02110}		
{02170} SS=D	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities;	{02170}		

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{02170}	Continued From page 33 (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced by:	{02170}		
{02310} SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by:	{02310}		
{03090} SS=C	144.6502, Subd. 8 Notice to Visitors Subd. 8.Notice to visitors. (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by:	{03090}		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF CONDITIONAL LICENSE

Electronically Delivered

December 20, 2022

Administrator
Scandia Capital Partners LLC
101 North 58th Avenue West
Duluth, MN 55807

RE: Conditional License Number 408489
Health Facility Identification Number (HFID) 24431
Project Number(s) SL24431015

Dear Administrator:

The Minnesota Department of Health (MDH) completed a licensing evaluation on November 23, 2022, for the purpose of assessing compliance with state licensing statutes. During the on-site evaluation, five (5) harm level immediate orders were identified. The licensees failure to document actions taken to comply resulted in the orders remaining immediate. Based on the licensing evaluation results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, MDH is issuing a 90-day conditional license due to expire on **March 20, 2022**.

INFORMAL CONFERENCE:
In accordance with Minn. Stat. § 144A.475, Subd. 8 OR Minn. Stat. § 144G.20, Subd. 20, the Commissioner of Health is authorized to hold a conference to exchange information, clarify issues, or resolve issues.

The Department of Health staff would like to schedule an informal conference with Scandia Capital Partners LLC. Please contact Jessica Chenze at 218-332-5175 on or before Thursday, December 22, 2022, to schedule the informal conference.

LICENSING ORDERS
The enclosed State Form documents the state licensing orders. The Department of Health documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for 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 . . ."

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

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

In accordance with Minn. Stat. § 144G.20, Subd. 4(a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572. Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

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

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

St - 0 - 0110 - 144g.10 Subdivision 1a - Assisted Living Director License Required - $3,000.00
St - 0 - 0340 - 144g.30 Subd. 5 - Correction Orders - $3,000.00
St - 0 - 0470 - 144g.41 Subdivision 1 - Minimum Requirements - $3,000.00
St - 0 - 0495 - 144g.41 Subd. 1 (14) - Minimum Requirements - $3,000.00
St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00
St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - $3,000.00
St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $3,000.00

The total amount you are assessed is $18,500.00. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

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

plan of correction for approval.

The correction order documentation should include the following:

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

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

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

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

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

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

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

CONDITIONAL LICENSE ISSUED:
MDH will issue Scandia Capital Partners LLC a conditional 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 evaluation, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the follow-up evaluation, MDH will determine if Scandia Capital Partners LLC is in substantial compliance.

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

a. **No new substantiated maltreatment allegations:** If any new investigations begin in the conditional license period, and the allegations are substantiated, MDH may pursue additional enforcement actions up to and including immediate temporary suspension and revocation of the license.

b. **Fill vacant positions:** Scandia Capital Partners LLC must fill the vacant Assisted Living Director and Clinical Nurse Supervisor positions with appropriately licensed individuals by December 27, 2022.

c. **No new admissions:** Scandia Capital Partners LLC will not admit any new residents under its conditional assisted living facility license until the MDH removes the "no new admissions" condition. Scandia Capital Partners LLC must provide the Department:

    i. A list of the names and birthdates of any individuals Scandia Capital Partners LLC 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

d. **Consultant:** Scandia Capital Partners LLC will contract with an RN to provide consultation concerning all resident(s) to whom Scandia Capital Partners LLC provides licensed assisted living services under the conditional license. <u>The consultant must have access to all resident(s) receiving services from Scandia Capital Partners LLC. 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</u>. The RN must not have any affiliation with Scandia Capital Partners LLC and MDH must

review the RN's credentials and approve the selection. Scandia Capital Partners LLC is responsible for the expense of the contract with the RN. The main purpose of the consultant is to provide guidance to Scandia Capital Partners LLC in an effort to help Scandia Capital Partners LLC 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. Scandia Capital Partners LLC 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.

e. 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 Scandia Capital Partners LLC and the RN consultant about a change. Each report will be electronically submitted to Jessica Chenze, Evaluator Supervisor, State Evaluation Team, Health Regulation Division, at jessica.chenze@state.mn.us. Jessica Chenze can be reached at 218-332-5175 (office) with questions about reports. The content of the reports will include information such as:

i. Progress towards correction of licensing 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).

f. Monitoring visits: MDH may make unannounced monitoring visits to assess the progress of Scandia Capital Partners LLC to correct the violations cited during the evaluation as well as to determine the overall practice of Scandia Capital Partners LLC 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 licensed assisted living services. The OOLTC will share their findings with MDH.

g. Follow-up Evaluation: At the time of the follow-up evaluation, MDH may pursue additional enforcement actions, up to and including immediate temporary suspension or revocation of the license if MDH identifies any level 3 or 4 violations or widespread care related violations.

h. Corrective Action Plan: Scandia Capital Partners LLC 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 LICENSE PERIOD:
MDH will determine if Scandia Capital Partners LLC is in substantial compliance based on the results of the follow up evaluation. MDH will make this determination within the 90-day conditional license period. If MDH determines Scandia Capital Partners LLC is in substantial compliance on the follow up evaluation, MDH will remove the conditions from Scandia Capital Partners LLC's assisted living facility license, and Scandia Capital Partners LLC will correct violations identified during the evaluation to come into substantial compliance. If MDH determines Scandia Capital Partners LLC is not in substantial compliance, MDH may take additional enforcement action against Scandia Capital Partners LLC, including placement of additional conditions, issuing a second conditional license, or employ any of the enforcement tools listed in Minn. Stat. § 144G.20 up to and including immediate temporary suspension and revocation.

REQUESTING A HEARING:
Pursuant to Minn. Stat. §144G.20, Subd. 17 (c), the licensee may appeal an order immediately temporarily suspending a license or issuing a conditional license. The appeal must be made in writing by certified mail or personal service. If mailed, the appeal must be postmarked and sent to the commissioner within five calendar days after the license holder receives notice. If an appeal is made by personal service, it must be received by the commissioner within five calendar days after the license holder received the order. The request for hearing should be addressed to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970
Health.HRD.Appeals@state.mn.us

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this notice and the results of this visit with the President of your organization's Governing Body.

If you have any questions, please contact Jessica Chenze directly at: 218-332-5175.

Sincerely,

Maria King, RN
Division Director

Minnesota Department of Health
Health Regulation Division

HHH

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0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL#24431015 On November 21, 2022, through November 23, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were nine (9) residents, all of whom were receiving services under the provider's Assisted Living with Dementia Care license. Immediate correction orders were identified on November 22, 2022, issued for SL#24431015, tag identifications 0110, 0495 and 2310. Additional immediate correction orders were identified on November 23, 2022, tag identifications 0470 and 1290. On November 23, 2022, at approximately 4:25 p.m., the surveyors exited the facility. As of the time of exit, immediacy remained in effect for all	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	

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0 000	Continued From page 1 issued immediate correction orders: 0110, 0470, 0495, 1290, and 2310.	0 000		
0 110 SS=I	144G.10 Subdivision 1a Assisted living director license required Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensee had a licensed assisted living director (LALD). This had the potential to affect all the licensee's 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). This resulted in a correction order on November 22, 2022, at approximately 11:30 a.m. On November 23, 2022, at approximately 10:00 a.m. the level of this order was increased to a level three violation, but remained at widespread scope, due to the following two additional level three immediate orders: 1290 and 2070, both issued at widespread scope. The time period to correct 0110 remains immediate.	0 110		

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0 110	Continued From page 2 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: The licensee lacked an LALD to oversee the facility. On November 21, 2022, at approximately 10:35 a.m., registered nurse (RN)-C stated she was not sure who the LALD was for the facility and it was possible, regional director/licensed practical nurse (RD/LPN)-D was the LALD for the facility. On November 21, 2022, at 11:24 a.m., RD/LPN-D stated she was not the LALD for the site. RD/LPN-D stated she is working on it [becoming LALD for the site] and added she is a LALD for other sites. RD/LPN-D stated the registered nurse who no longer works at this facility was the LALD for this facility. No further information was provided. TIME PERIOD OF CORRECTION: IMMEDIATE As of the time of exit on November 23, 2022, immediacy was not removed.	0 110		
0 250 SS=F	144G.20 Subdivision 1 Conditions	0 250		

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0 250	Continued From page 3 (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a 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; (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 section 144.057 or 245A.04;	0 250		

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0 250	Continued From page 4 (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: During the entrance conference on November 21, 2022, at 11:37 a.m., owner/agent (A/O)-E stated he was "somewhat familiar" with the current	0 250		

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	24431	A. BUILDING: _____ B. WING _____	11/23/2022

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0 250	Continued From page 5	0 250		

assisted living laws and regulations, adding "I own the company, I hire people, I don't personally," the licensee's employees in charge of the facility were familiar with the assisted living regulations and the licensee provided medication and treatment management services.

The licensee's Application for Assisted Living License, section titled Official Verification 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. [Minnesota] Stat. [statute] sect. [section] 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 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

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0 250	Continued From page 6 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 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.	0 250		

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0 250	Continued From page 7 - 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 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 five was electronically signed by regional director/licensed practical nurse (RD/LPN)-D on May 12, 2022. The licensee had an assisted living license issued on August 1, 2022, with an expiration date of April 30, 2023. The licensee failed to ensure the following policies and procedures were developed and/or implemented: (1) requirements in section 626.557, reporting of maltreatment of vulnerable adults; (2) conducting and handling background studies on employees; (3) orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; (4) handling complaints regarding staff or services provided by staff; (5) conducting initial evaluations of residents' needs and the providers' ability to provide those services; (6) conducting initial and ongoing resident evaluations and assessments of resident needs,	0 250		

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0 250	Continued From page 8 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; (7) infection control practices; (8) conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; (9) medication and treatment management; and (10) delegation of tasks by registered nurses or licensed health professionals; On November 23, 2022, at 4:11 p.m., RD/LPN-D stated they lacked an understanding of 144G statutes for reporting of maltreatment of vulnerable adults, conducting and handling background studies on employees, orientation, training, and competency evaluations of staff, handling complaints regarding staff or services provided by staff, conducting initial evaluations of residents' needs and the providers' ability to provide those services, 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, infection control practices, conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; medication and treatment management, delegation of tasks by registered nurses, and failed to implement corresponding policies and procedures, as required.	0 250		

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0 250	Continued From page 9 As a result of this survey, the following orders were issued 0110, 0250, 0340, 0470, 0480, 0495, 0510, 0550, 0580, 0630, 0640, 0660, 0660, 0680, 0730, 0790, 0800, 0810, 0940, 0950, 0970, 1290, 1370, 1380, 1470, 1540, 1620, 1640, 1650, 1750, 1760,1790, 1880, 1890, 1910, 1950, 1960, 2040, 2110, 2170, 2310 and 3090 indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250		
0 340 SS=I	144G.30 Subd. 5 Correction orders (a) A correction order may be issued whenever the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, or an employee of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail or e-mail copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must document in the facility's records any action taken to comply with the correction order. The	0 340		

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0 340	Continued From page 10 commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have sufficient documentation with actions taken to comply with the immediate order, tag identification 0110, 0470, 0495, 1290, and 2310, during a survey completed on November 23, 2022. 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 November 23, 2022, the Minnesota Department of Health completed a survey resulting in 40 correction orders issued and immediate orders 0110, 0470, 0495, 1290, and 2310 issued on November 22, 2022, and November 23, 2022. On November 22, 2022, at 12:02 p.m., owner/agent (O/A)-E was notified by MDH of immediate correction orders for tags 0110, 0495, and 2310. On November 22, 2022 at 4:10 p.m., O/A-E was	0 340		

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0 340	Continued From page 11 contacted by Minnesota Department of Health (MDH) regarding the plan of correction for 3 immediate corrections orders. On November 23, 2022 at 9:00 a.m., O/A-E acknowledged the immediate correction orders and stated he "immediately set it [orders/email] to regional director/licensed practical nurse (RD/LPN)-D. O/A-E requested a phone conversation. On November 23, 2022, at 9:15 a.m., MDH replied to O/A-E offering to answer questions via email. O/A-E was reminded MDH was unable to consult. On November 23, 2022, at 9:39 a.m., O/A-E replied stated the facility has been actively interviewing for registered nurse (RN) positions for "a month and hope to have a new hire soon." O/A-E asked for clarification according to the order on a deadline for completing a RN hire. On November 23, 2022, at 9:53 a.m., MDH replied "The statute requires that an RN be accessible at all times to staff: 144G.41, Subd 1. (14) provide staff access to an on-call registered nurse 24 hours per day, seven days per week. During this survey, that has been demonstrated to not be the case. The time frame for correction is immediate, therefore, in your plan of correction you submit, you need to identify how you will remedy this situation immediately." On November 23, 2022 at 8:55 a.m., RD/LPN-D's email address was sent to MDH for further communication. On November 23, 2022, at 1:39 p.m., RD/LPN-D and O/A-E were notified via email of additional	0 340		

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0 340	Continued From page 12 immediate correction orders for tags 0470 and 1290. As of the time of exit on November 23, 2022, neither RD/LPN-D or O/A-E had communicated a plan of correction to MDH. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 340		
0 470 SS=I	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents;	0 470		

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0 470	Continued From page 13 (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensue one or more persons were available 24 hours a day, seven days a week who were responsible for responding to requests of residents for assistance. In addition, the licensee failed to ensure the facility was staffed sufficiently to assist with resident needs for four of four residents (R5, R9, R2, R4), as well as failure to develop and implement a staffing plan. This resulted in an immediate correction order on November 22, 2022. 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: The licensee held an assisted living with dementia care license and was licensed for a bed capacity of 10 residents. The current census at the facility was nine (9). STAFF AVAILABILITY November 21, 2022, at approximately 10:20 a.m.,	0 470		

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0 470	Continued From page 14 unlicensed personnel (ULP)-B stated "it happens" in reference to the need to leave the building unattended by staff. "To go get something in the other building (across the street from facility)." ULP-B was not able to identify a day or time that she left the building unattended. On November 23, 2022, at approximately 7:40 a.m., ULP-J stated in the evening she takes the garbage out, and the recycling on occasion and has to leave the building to do this. The garbage dumpster was located in the circular driveway near the parking area. ULP-J pointed out the window and stated the recycling dumpster is across the street in the other house's driveway. RESIDENT'S NEEDS R5 R5's 90-day assessment dated March 1, 2022, indicated R5 needed assistance with toileting and bathing. R5 received assistance with showers 2 times a week, with some refusals. On November 22, 2022, at 6:47 a.m., the surveyor observed ULP-B give R5 her morning medications and assist her with a shower, washing her back and hair. At 7:02 a.m., the surveyor observed two residents seated at the dining room table and a third at a common area table doing a jigsaw puzzle. R9 R9's Care Plan dated November 2022, indicated R9 required total assist with bath/shower one day a week or more as needed (prn), assist with dressing in the morning and evening, 1 staff to supervise/assist for safety in ambulation 10 times a day, 1 staff to supervise/assist with toileting every 2 hours (10 times per day) and 1 staff to	0 470		

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0 470	Continued From page 15 supervise/assist for safety in ambulation then times daily. On November 22, 2022, at 7:17 a.m., the surveyor observed ULP-B administer R9's morning medication, weight, eye drops, topical cream to lower legs, and apply TEDs. R2 R2's service plan, dated September 1, 2022, indicated R1 needed assist of one to shower, received one shower a week. On November 22, 2022, at 3:38 p.m., R2 stated staff assists her with the shower and help me wash my hair, my back and my legs. R2 said they helped her a few times, but then when R4 was supposed to have the shower, staff began to show up late, adding she was to have the shower around 7:00 p.m. R2 said staff were coming in at 8 or 8:30 p.m., and I wanted to go to bed, so I started doing the shower on my own. R4 R4's record contained an undated, started service plan with some medications listed. On November 22, 2022, at 4:06 p.m., R4 stated she had been here, "at this place" a year, mentioning October 2021. R4 stated, "they do almost everything. Staff wash/laundry bed linens, clothing; get meals here. I often skip breakfast, I get medications, like 10 pills in the morning. They are usually here by 8 to 8:10 a.m. They take care of ordering. I don't do nothing with that, if we need more, they store the meds, they pass them out, I get one before supper, they stand and watch you take the pill. R4 stated she is able to dress herself. Staff assisted with the shower, adding "they are there the whole time, they stand right by	0 470		

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0 470	Continued From page 16 me when I take shower and wash my back and help with the hair." On November 23, 2022, at 8:59 a.m., the surveyor requested to review the facilities written staffing plan. RD/LPN-D stated "we don't have written documentation" of a staffing plan. On November 23, 2022, at 9:04 a.m., regional director/licensed practical nurse (RD/LPN)-D stated there was staff here to cover when the trash needed to be taken out. RD/LPN-D mentioned several staff that are in or could be in the building Monday through Friday. RD/LPN-D acknowledged on the weekends there is only one staff working. RD/LPN-D added community coordinator (CC)-A and maintenance director (MD)-I might stop in. RD/LPN-D stated staff are not supposed to leave the building we are a 24/7 staff on site location. RD/LPN-D acknowledged the staff worked 12-hour shifts. RD/LPN-D stated trash could be taken out at the end of the shift. On November 23, 2022, at 9:04 a.m., RD/LPN-D stated most of the residents are independent. RD/LPN-D added each shift and staff have steps/things they need to do. Staff come and do medications; we do the meals, and "I thought they [residents] were independent with showers." RD/LPN-D added if is there was an emergency the staff would need to call 911. RD/LPN-D acknowledged on weekends there is only one staff scheduled for each 12-hour shift at the facility. On November 23, 2022, at 1:00 p.m., the surveyor reviewed the staffing schedule for November 2022. The schedule indicated one direct care staff was on the schedule from 6:00 a.m. to 6:00 p.m., and one direct care staff was	0 470		

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0 470	Continued From page 17 on the schedule form 6:00 p.m. to 6: 00 a.m. daily. RD/LPN-D stated no ancillary staff was on the schedule. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate As of the time of exit on November 23, 2022, immediacy was not removed.	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a	0 480		

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	24431	A. BUILDING: _____ B. WING _____	11/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCANDIA CAPITAL PARTNERS LLC	101 NORTH 58TH AVENUE WEST DULUTH, MN 55807

(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
0 480	Continued From page 18 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated November 21, 2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 495 SS=I	144G.41 Subd. 1 (14) Minimum Requirements (14) provide staff access to an on-call registered nurse 24 hours per day, seven days per week. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure that a registered nurse (RN) was available on-call 24 hours a day, seven days per week. This had the potential to affect all nine (9) residents and staff of the facility. 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).	0 495		

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0 495	Continued From page 19 This resulted in a correction order on November 22, 2022, at approximately 11:30 a.m. The findings include: On November 21, 2022, at approximately 9:35 a.m., the surveyor observed one unlicensed personnel (ULP)-B working at the facility. ULP-B stated, "we don't have a RN. We don't have one period." ULP-B added regional director/licensed practical nurse (RD/LPN) comes here two (2) times a week. ULP-B motioned to a list of numbers posted on a long door, "there is no number posted for the current RN." There were two RNs names and numbers posted, however ULP-B stated, neither are "here" [work at facility]." ULP-B again stated, "have not had one [RN] for about a month." On November 21, 2022, at 9:49 a.m., the surveyor called the number owner/agent (O/A)-E gave the surveyor to speak to RN. The number given went to a voice mail and the mailbox was full. The surveyor contacted O/A-E again and he stated "she [RN] is a fill in until next hire." O/A-E added it was "not acceptable" RN-C did not answer the phone and having no space for messages. Later, O/A-E contacted the surveyor, to acknowledge he gave the incorrect number out for RN, "that is her personal number." On November 21, 2022, at 1:50 p.m., R3 told staff, in a joking tone they [staff] were not going to like the new orders received earlier that day from an appointment with her health care provider. R3's prescriber's order dated November 21, 2022, included "Healing well since ablation [the removal or destruction of something from an object] Sob (shortness of breath) with exertion	0 495		

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0 495	Continued From page 20 and heart logic elevated on device which indicated possible volume overload. Take additional torsemide (used to help treat fluid retention (edema) and swelling that is caused by congestive heart failure) 10 milligrams (mg) this afternoon and an additional tomorrow afternoon if blood pressure allows. Do not admin if SBP (systolic blood pressure/phase of the heart when working/contracting) less 100 mmHg [represents a millimeter of mercury]. Continue other meds without change." On November 21, 2022, at approximately 2:00 p.m., community coordinator (CC)-A looked at the new order R3 received and stated she would fax it to RD/LPN-D. On November 21, 2022, at 2:56 p.m., a fax was received of a medication administration record (MAR) with R3's name on it and torsemide 10 mg, give an additional torsemide 10 mg by mouth this afternoon and an additional torsemide 10 mg tomorrow afternoon if blood pressure allows, Do not administer if systolic blood pressure less than 100 MM HG. On November 21, 2022, at 2:57 p.m., ULP-B looked at the fax and stated "it" [MAR] was incorrect as the times were wrong. On November 21, 2022, at approximately 3:10 p.m., ULP-B called RD/LPN-D and made her aware of her concerns with the MAR. RD/LPN-D stated she was on her way to the dentist, and she would fix it and fax it back. On November 22, 2022, at 5:30 a.m., ULP-F introduced herself to the surveyor. ULP-F stated there are medication errors and asked the surveyor if she wanted to see. ULP-F took the	0 495		

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0 495	Continued From page 21 surveyor to a locked office and pulled out a wicker basket. There were ten (10) little envelopes in the basket with medications names, dates, times and resident names on them. ULP-F stated nothing was done with the medication errors, "no RN." ULP-F stated she calls LPN-G (LPN who works at two other sites/not at this facility, "she used to work here") and LPN-G "sometimes" answer her phone. ULP-F stated there has been no RN to call for "1.5 months" adding ULP-F used to call the RN at the facility. On November 22, 2022, at 9:38 a.m., the surveyor called RN-C regarding a question. RN-C was unable to answer the question stating, "Outside of that one admission I did, I can't help you. I can't help you with anything up there [facility]. I wish I could." On November 22, 2022, at 11:00 a.m., ULP-B contacted CC-A regarding R3's medication order. On November 22, 2022, at 11:26 p.m., the surveyor asked ULP-B if CC-A replied to her question regarding R3's medication order. ULP-B pulled out her phone, looked at it and stated, "nope." No further information provided. TIME PERIOD OF CORRECTION: IMMEDIATE As of the time of exit on November 23, 2022, immediacy was not removed.	0 495		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that	0 510		

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0 510	Continued From page 22 complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure infection control standards were followed for two of two unlicensed personnel (ULP-B, ULP-J) during personal cares for R3, R5. In addition, the licensee failed to ensure reusable equipment was cleaned in-between resident use. 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: HAND HYGIENE ULP-B On November 21, 2022, at 3:12 p.m., the surveyor observed ULP-B remove one medication from a locked medication cart, put the medication into a med cup and take medication to	0 510		

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0 510	Continued From page 23 R8's room. ULP-B gave the medication to R8. ULP-B then went to R8's closet and got a blanket for her. R8 requested a bigger blanket, ULP-B returned the smaller blanket to the closet and brought a larger blanket to R8. ULP-B left R8's room and went to document in R8's medication administration record (MAR). ULP-B put R8's MAR, which was kept in a binder away. ULP-B went to the medication cart and looked for a medication for R3. ULP-B was not able to locate the medication and asked for assistance from community coordinator CC-A. ULP-B did not complete hand hygiene at any time during this part of the surveyor's observation. On November 21, 2022, at 3:24 p.m., ULP-B stated she performs hand hygiene prior to medication administration. ULP-B confirmed she had not performed hand hygiene. ULP-J On November 23, 2022, at 7:51 a.m., the surveyor observed ULP-J remove R5's morning medication from a locked medication cart and bring the medication to R5. ULP-J set the medication down on a side table located near R5. ULP-J left R5's room and went to the kitchen and filled up R5's glass with ice and water. ULP-J took the filled glass back to R5 and returned to the kitchen. ULP-J put on gloves and went to the freezer to get breakfast started for R7. ULP-J did not complete hand hygiene at any time during this part of the surveyor's observation. On November 23, 2022, directly following the above observation, ULP-J stated she washes hands before working with medication, adding R7 was hungry. ULP-J confirmed she did not perform hand hygiene after giving medication, or before putting on gloves.	0 510		

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0 510	Continued From page 24 DISINFECTING EQUIPMENT BETWEEN USE On November 22, 2022, at 2:39 p.m., the surveyor observed ULP-B remove a blood pressure (BP) cuff out of the medication cart and R3's afternoon medication and take the BP cuff and R3's medication to R3's room. ULP-B placed the BP cuff on R3's out reached left arm. ULP-B took R3's BP and then handed the medication cup to R3. After ULP-B administered R3's medication ULP-B returned the BP cuff to a drawer in the locked medication cart. ULP-B did not disinfect the blood pressure cuff prior to or after equipment use. On November 22, 2022, directly following the above observation ULP-B stated she had not remembered to clean the BP cuff after using the BP cuff. On November 23, 2022, at 4:02 p.m., regional director/licensed practical nurse (RD/LPN)-D confirmed equipment, such as blood pressure cuffs should be cleaned between all residents and hands should be washed for 20 seconds or sing "happy birthday." The licensee's Infection Control policy dated August 1, 2021, indicated facility staff would observe the recommended precautions for home care as identified by the Centers for Disease Control and Prevention (CDC). The precautions cover those clients with documented or suspected infection with highly transmissible or epistemologically important pathogens that require additional precautions to prevent transmission. The practice of employees will conform with OSHA regulation, current law and currently accepted standards of practice. Hands	0 510		

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0 510	Continued From page 25 are washed if contaminated with blood or body fluid, immediately after gloves are removed, between client contacts, and when indicated to prevent transfer of microorganism between client or the environment. In addition, equipment used for client care is properly cleaned and reprocessed. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post the required information related to the grievance procedure, as well as information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC). This had the potential to affect all current residents, staff and visitors.	0 550		

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0 550	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, 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 November 21, 2022, at approximately 2:00 p.m., the surveyor toured the facility with community coordinator (CC)-A. The main entrance and/or common areas lacked the required posting for the grievance procedure to include the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. On November 21, 2022, at 2:06 p.m., CC-A stated the required grievance procedure content had not been posted. CC-A added it was posted across the street in the other building. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 550		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that	0 580		

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	24431	A. BUILDING: _____ B. WING _____	11/23/2022

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0 580	Continued From page 27 have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to engage in and maintain documentation of quality management activity appropriate to the size and relevant to the type of services provided by the assisted living. This had the potential to affect all 16 residents receiving assisted living services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On November 21, 2022, at 11:10 a.m., during the entrance conference with registered nurse (RN)-C, a request was made to review documentation of the licensee's quality management activities. RN-C stated she believed the facility had a quality management program and they met "quarterly if not sooner." On November 23, 2022, at 1:10 p.m., community coordinator (CC)-A stated every single	0 580		

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0 580	Continued From page 28 Wednesday "we" go over any issues with nursing." On November 23, 2022, at 3:57 p.m., CC-A confirmed they do not have any documentation of quality management activities. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 580		
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop an individual abuse prevention plan with all required content for one of three residents (R2). 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	0 630		

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0 630	Continued From page 29 cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 was admitted to the assisted living facility on September 1, 2021. R2's service and care plan, each dated September 1, 2022, indicated services included: medication management (with four times daily medication administration), weekly showers with standby assist of 1 staff, monitoring of weight and blood pressure, and treatment of compression hose (TEDs) application and removal. On November 22, 2022, at 3:33 p.m. the surveyor observed R2 independently ambulate using a front-wheeled walker and took a seat in a recliner chair in her room. R2 was wearing compression stockings. R2 stated she was "pretty much independent here,"staff assisted her with showers, that they provided her medications, meals and had housekeeping and laundry services from the facility. R2's record lacked an individual abuse prevention plan that included assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults (VA); the person's risk of abusing other VAs; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other VAs. On November 23, 2022, at 10:47 a.m., regional director/licensed practical nurse (RD/LPN)-A	0 630		

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0 630	Continued From page 30 stated R2 should have a vulnerability assessment, that the abuse prevention plan was one the required admission assessments completed by the RN (registered nurse). RD/LPN-D did not know why R2 had no abuse prevention plan and said "it should be there." The licensee's Assessment - Comprehensive Services policy, dated August 1, 2021, indicated an individualized initial evaluation of all new clients shall be completed on admission by a registered nurse (RN) in order to develop a personalized service plan. The policy directed the RN will provide the admission visit and conduct assessment, including a vulnerability assessment. The policy did not describe content of the vulnerability assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language.	0 640		

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0 640	Continued From page 31 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post required content in common areas to include posting the 911 emergency number in common area and near telephones provided by the assisted living. This had the potential to affect all 9 residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On November 21, 2022, at approximately 2:00 p.m., the surveyor toured the facility with community coordinator (CC)-A. The surveyor observed one phone in the kitchen and CC-A stated there was a phone in the nurse's station that residents could use. The surveyor did not observe 911 posted on or near the telephones in the commons area as required. On November 21, 2022, at 2:07 p.m., CC-A confirmed the 911 emergency number was not posted on or near the telephones. CC-A was not aware of the requirement. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24431	A. BUILDING: _____ B. WING _____	11/23/2022

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0 660	Continued From page 32	0 660		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a TB (tuberculosis) prevention and control program based on the most current guidelines issued by the centers for Disease Control and Prevention (CDC) guidelines and the Minnesota Department of Health (MDH). The licensee lacked a current, updated TB risk assessment; failed to identify who from the facility was currently in charge of the TB Plan; and failed to ensure one of two unlicensed personal (ULP)-B was screened and tested for active TB and documentation retained in the employee's record. This had the potential to affect all 9 residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 660		

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0 660	Continued From page 33 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: TB RISK ASSESSMENT and TB PLAN The licensee's Facility TB Risk Assessment Worksheet for Health Care Setting Licensed by MDH (Minnesota Department of Health) dated June 8, 2021, indicated the TB risk level of this setting was low. The licensee's facility TB risk assessment was not updated at least annually as required. On November 21, 2022, at 2:43 p.m., the surveyor reviewed the facility's TB risk assessment with community coordinator (CC)-A. CC-A stated the person responsible for TB infection control listed on the risk assessment dated June 8, 2021, was no longer working at the facility. In addition, none of the three other names listed as members of the infection control committee currently worked at the facility. In the file that contained the TB risk assessment dated June 8, 2021, was a blank TB risk assessment with a sticky note stating, "due June 2022." CC-A stated the TB risk assessment for the facility had not been completed as required. TB EMPLOYEE SCREENING/TESTING ULP-B was hired January 23, 2021, and began providing direct care and assisted living services	0 660		

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0 660	Continued From page 34 August 1, 2021, to the licensee's residents. ULP-B's employee record lacked documented evidence of a two-step tuberculin skin test (TST), Interferon Gamma Release Assay (IGRA) blood test or other evidence the employee is free from active TB. On November 23, 2022, at 10:33 a.m., regional director/licensed practical nurse (RD/LPN)-D said staff are required to be screened for TB at hire, which included the TB symptoms screen and the TST or blood test results. RD/LPN-D stated ULP-B should have this in her employee file and could not understand why it was not. The licensee's TB Screening/Prevention policy, dated August 1, 2021, indicated the facility will observe the recommended precautions related to TB prevention. The policy indicated baseline testing is required for all health care workers and consists of two components: assessing for current symptoms of active TB and testing for the presence of infection with either a two-step TST or single blood test. Staff include both paid and unpaid direct care givers. The policy also indicated the administrator was responsible to conduct the formal risk assessment, that procedures should be reviewed annually and updated if necessary. The MDH guidelines, "Regulations for Tuberculosis Control in Minnesota Health Care Settings" dated July 2013, and based on CDC guidelines, indicated all health care settings in Minnesota should perform an initial facility TB risk assessment. A TB infection control program should include the following: written TB infection control procedures. HCWs education should focus on basic information about your health care	0 660		

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0 660	Continued From page 35 setting's infection control plan (i.e., how to implement your early recognition, isolation, and referral procedure), especially any sections that employees are responsible for implementing. The guidelines also indicated an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record." 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 all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and	0 680		

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0 680	Continued From page 36 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 develop an emergency preparedness plan (EP) with all required content or practice and document testing of its plan at least twice annually as required. In addition, the licensee failed to ensure its missing resident plan had all required content and evaluate/revise its plan at least quarterly. This had the potential to affect all 9 residents, staff and visitors of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: During the entrance conference on November 21, 2022, at 11:11 a.m., the surveyor requested to view the facility's emergency plan and related documentation, which was later provided. EMERGENCY PREPAREDNESS PLAN and	0 680		

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0 680	Continued From page 37 TESTING The licensee's "Emergency Preparedness Manual," undated, was a binder that contained information about emergency preparedness (EP) planning. The document included: ownership information, a building emergency exit diagram, management/nursing contact list, agreement with a nursing facility for temporary housing and general directions listing chain of command and basic roles during an emergency. The EP plan provided to surveyors referenced state statutes for license type the provider no longer used, contained no evidence the plan was recently reviewed and listed ownership and contact information dated April 23, 2019. The agreement for temporary housing with a nursing facility listed contact phone numbers and administrator's name; the document was undated. The contact names listed in the EP plan no longer owned or were employed by the facility. The EP plan also lacked evidence documenting the licensee's testing of the plan at least twice annually. The licensee's emergency preparedness plan lacked the following components: -current, all-hazards approach facility assessment; -description of the population served by licensee; -process for emergency preparedness cooperation with state and local EP officials/organizations; -subsistence needs for staff and residents during emergency situation; -procedure for tracking staff and residents; -development of all policies/procedures, based on assessment; and additional policies for: -potential evacuation; -sheltering in place; -handling medical documents;	0 680		

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0 680	Continued From page 38 -handling and use of volunteers; -arrangement with other faculties (including sister facilities); -development of a communication plan, including primary and alternate means for communication; -methods for sharing information; -EP training and testing program; -EP training program for staff (including documentation of training provided); and -annual EP testing requirements. MISSING PERSON POLICY The surveyor reviewed the facility's Missing Resident policy, dated May 9, 2019. The policy lacked required content including: -identify a staff member for each shift who is responsible for implementing the missing resident plan, and ensure a least one staff member who is responsible for implementing the missing-resident plan is on site 24 hours a day, seven days a week; -require that staff immediately contact the resident's representatives and the resident's case manage, if applicable when a resident is determined missing. Additionally, there was no evidence the assisted living director and clinical nurse supervisor reviewed the missing resident plan at least quarterly or documented any changes to plan. On November 23, 2022, at 11:54 a.m., regional director/licensed practical nurse (RD/LPN)-D said the emergency plan in the binder contained names and contact information from former owners and staff no longer working here, and those plan documents were not current, would provide the updated plan. RD/LPN-D said she would check with the facility's maintenance	0 680		

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0 680	Continued From page 39 director regarding mock drills and any documentation for testing of the emergency plan. RD/LPN-D also said the RN (registered nurse) was responsible to review the missing resident plan/policy, which was done at weekly meetings, but said she had no documentation as far a a review of the missing plan. RD/LPN-D added there was more to the missing resident plan and would provide that later. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans;	0 730		

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0 730	Continued From page 40 (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record included the required content for one of one resident (R4). In addition, the licensee failed to ensure the resident's record included documentation services were provided for two of two residents (R9, 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) and was issued at a widespread scope (when problems are pervasive	0 730		

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0 730	Continued From page 41 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: REQUIRED CONTENT R4 was admitted for services on September 22, 2021. R4's record included: - an unsigned and undated list of R4's medication in the front of R4's record; -an undated nursing/progress note, with one entry; -Assessment for Need for Medication Reminders, Assistance, Administration or Central Storage dated December 14, 2021; and -prescriber's orders dated May 16, 2022, May 18, 2022, May 19, 2022, May 27, 2022, August 24, 2022, October 13, 2022, November 15, 2022, respectively. R4's record was lacking identifying information, including the resident's name, date of birth, address, and telephone number; -the names, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative: -treatments or therapies that required documentation and other relevant health records; -the resident's advance directives, if any; -copies of any health care directives, guardianships, powers of attorney, or conservatorships; -the facility's current and previous assessments and service plans; -records of communications pertinent to the resident's series;	0 730		

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0 730	Continued From page 42 -documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; -documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; -documentation that service had been provided as identified in the service plan; -documentation that the resident had received and reviewed the assisted living bill of rights; -documentation of complaints received and any resolution; and - other documentation require under this chapter and relevant to the resident's services or status. On November 21, 2022, at 4:14 p.m., the surveyor requested R4's record from community coordinator (CC)-A. CC-A stated it might be in the garage. On November 23, 2022, at 3:55 p.m., regional director/licensed practical nurse (RD/LPN)-D stated R4's record would not be located in the garage. RD/LPN-D and CC-A stated they were not sure what happened to the "items" in R4's record. RD/LPN-D and CC-A looked around in the office for R4's records but they were unable to locate them. CC-A said she herself had put the "items" in "that" [R4's] "file"/record. RD/LPN-D stated "they" [facility] would need to redo it "all" since they were unable to find the items. DOCUMENTED SERVICES R9 R9's diagnoses included congested heart failure (CHF-condition in which the heart's function as a	0 730		

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0 730	Continued From page 43 pump is inadequate to meet the body's needs) depression, and edema. R9's Care Plan dated November 2022, indicated R9 required total assist with bath/shower one day a week or more as needed (PRN), assist with dressing in the morning and evening, set up/supervise grooming, staff to supervise/assist for safety in ambulation 10 times a day, assist with all transfers 8 times daily, staff to supervise/assist with toileting every 2 hours (10 times per day), weekly showers with standby assist of staff, housekeeping, and laundry services. R9's Treatment Plan: Addendum to Service Plan, dated November 14, 2022, indicated R9 required assistance with compression stockings (TED), creams, and staff to set up C-pap [noninvasive ventilation breathing support through a face mask, nasal mask, or helmet]. On November 22, 2022, at 7:17 a.m., the surveyor observed unlicensed personnel (ULP)-B administer R9's morning medication, obtain weight, administer eye drops, apply topical cream to lower legs, and apply TEDs. The surveyor observed a C-pap machine on a table near R9's bed. ULP-B stated she helps R9 with C-pap hoses "on occasion." R9's Daily Monitoring Flowsheet dated November 2022, included a space for staff to document bowel movements, "initial for shower/nails/linen change", document any refusals, and vital signs (blood pressure, pulse, respirations, temperature, oxygen, and weight). Documentation on daily flowsheet dated November 14, 2022 through November 22, 2022,	0 730		

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0 730	Continued From page 44 failed to include staff's initials to indicate the services were provided: -9 out of 9 opportunities day shift; and -8 out of 8 opportunities evening shift. R9's Care Plan dated November 2022, included a section for "caregiver" documentation, morning, evening, and night shift. The document was blank. R9's record failed to include verification R9 received the following services from November 14, 2022, through November 22, 2022: -15 of 15 opportunities for TEDs (application/removal); and -8 of 8 opportunities c-pap set up. R3 R3's diagnoses included CHF, chronic kidney disease (CKD- mild to moderate damage, kidneys are less able to filter waste and fluid out of blood), high blood pressure (HTN-high blood pressure), presence of cardiac pacemaker, presence of automatic implacable cardiac defibrillator. R3's service and care plan, each dated September 1, 2022, indicated services included: medication management (with five times daily medication administration), monitoring of weight, blood pressure and pulse daily, standby assist with shower, Monday evenings, housekeeping and laundry services On November 22, 2022, at 2:39 p.m., the surveyor observed ULP-B obtain R3's blood pressure and administer R3's afternoon medication. R3's record included, a Daily Monitoring	0 730		

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0 730	Continued From page 45 Flowsheet dated November 2022, included a space for staff to document bowel movements, "initial for shower/nails/linen change", document any refusals, vital signs (blood pressure (BP), pulse, respirations, temperature, oxygen, and weight), and November's 2022's medication administration record (MAR). Documentation on daily flowsheet dated November 1, 2022 through November 22, 2022, failed to include staff's initials to indicate services were provided: -15 out of 20 opportunities day shift; and -15 out of 20 opportunities evening shift. R3's record lacked documentation verifying R3 received the following scheduled services from November 11, 2022, through November 21, 2022: -1 of 1 opportunities shower. R3's Care Plan located in the binder with R3's MAR, dated September 2022, did not include a place for staff to document the services that had been provided. On November 23, 2022, at 12:19 p.m., RD/LPN-D stated there was "a problem" with staff documenting the services provided at the facility. The licensee's Clinical Record policy dated May 9, 2019, indicated a clinical record would be started for each client on admission to home care. All entries into the clinical record would be current, legible, permanently recorded in ink, dated and authenticated with the name and title of the person making the entry. Documentation would be entered into the clinical record no later than two weeks after the end of the day service was provided. The records would be stored in a locked, secured location accessible to employees	0 730		

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0 730	Continued From page 46 and contractors of the facility, another facility, other health care providers, or inpatient facility needing information to provide care authorized in writing to access the records or representatives of the commissioner authorized to survey or investigate the facility. Clinic records would be maintained in such a manner that allowed for timely access, printing or transmission of the records. The clinical record contains the following information; -client's name, address, telephone number, date of birth; - admission/discharge dates, names, addresses and telephone numbers of an emergency contact, facility members or responsible parties; - pertinent health information, medical history, allergies, advance directives, if any; -service plans, nursing assessments, medication, treatment and/or therapies if pertinent,; -documentation of communication/coordination pertinent to the client's home care services,; -documentation of incidents and/or significant changes in the client's status and actions taken in response to the needs of the client, including reporting to the appropriate supervisor or health professional; - documentation of services provided as identified in the service plan, documentation that the client has received and reviewed the following: Home Care Bill of Rights, Scope of Services policy; -grievances and resolution, as applicable; -discharge summary and related documentation, including service termination notice, when applicable; -names, addresses and telephone numbers of the client's health and medication services providers and other home health agencies, if known; and -other information needed to provide home health service.	0 730		

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0 730	Continued From page 47 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 730		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: 0790 Based on observation and interview, the licensee failed to provide portable fire extinguishers that were readily accessible and had no more than 75-foot travel distance within the facility. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	0 790		

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0 790	Continued From page 48 or has the potential to affect a large portion or all residents). The findings include: On November 21, 2022, from approximately 11:00 a.m. to 1:15 p.m., survey staff toured the facility with the Director of Maintenance (DM)-I. During the facility tour, survey staff observed the following: 1.The required fire extinguisher was located in an unlabeled closet and was not readily accessible for use or within 75-foot travel distance. (DM)-I verbally confirmed survey staff observations during the facility tour. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 790		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: 0800 Based on observation and interview, the licensee	0 800		

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0 800	Continued From page 49 failed to maintain the facility physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all residents). The findings include: On November 21, 2022, from approximately 11:00 a.m. to 1:15 p.m., survey staff toured the facility with the director of maintenance (DM)-I. During the facility tour, survey staff observed the following: 1.A portable space heater in resident room 10 was present with combustible storage on top of the heater and next to the heater. 2.There was a missing electrical box outlet cover in the mechanical room where the water heater recirculation pump is plugged in. 3.An extension cord not designed for overcurrent protection was used to permanently power the water heater recirculation pump. 4.There was no documentation available that required annual fire sprinkler system maintenance had been performed. 5.The exterior intake vent hoods for the building air exchanger system were dirty and plugged and would not allow fresh air to flow into the building.	0 800		

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0 800	Continued From page 50 (DM)-I verbally confirmed survey staff observations during the facility tour. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one	0 810		

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0 810	Continued From page 51 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: 0810 Based on observation, interview, and record review, the licensee failed to provide the required fire safety training and evacuation plans for residents and staff. This has 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, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all residents). The findings include: Survey staff requested fire safety training and evacuation plan documentation, but the licensee was not able to provide the documentation as follows: 1.Location and number of resident rooms. 2.Employee actions to be taken in the event of a fire or similar emergency. 3.Fire protection procedures necessary for residents. 4.Procedures for resident movement, evacuation, or relocation during a fire or similar emergency including identification of unique or unusual resident needs for movement or	0 810		

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0 810	Continued From page 52 evacuation. 5.Records of employee training on the fire safety and evacuation plans. 6.Records of training for residents that are capable of assisting in their own evacuation. 7.Records of required evacuation drills. 8.The plan shall be readily available at all times within the facility. During interview on November 21, 2022, at 1:00 p.m., (DM)-I confirmed the findings. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 940 SS=C	144G.50 Subd. 2 (e; 5-7) Contract information (5) a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: (i) whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; (ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); (iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; (iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of	0 940		

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0 940	Continued From page 53 time that private payment is required; (v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; (vi) a statement that residents may be eligible for assistance with rent through the housing support program; and (vii) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; (6) the contact information to obtain long-term care consulting services under section 256B.0911; and (7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to execute a written assisted living contract with the required content for two of two residents (R2, R3). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2 R2's service and care plan, each dated September 1, 2022, indicated services included: medication management (with four times daily medication administration), weekly showers with	0 940		

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0 940	Continued From page 54 standby assist of 1 staff, monitoring of weight and blood pressure and treatment of TED (thrombi-embolytic deterrent) hose application and removal. On November 22, 2022, at 3:33 p.m., the surveyor observed R2 independently ambulate using a front-wheeled walker and took a seat in a recliner chair in her room. R2's record included an Assisted Living with Dementia Care Contract, signed by R2 on September 1, 2022. R3 R3's service plan, dated September 1, 2022, indicated services included: medication management, daily medication administration, weekly showers and monitoring of weight and blood pressure. On November 22, 2022, at 2:39 p.m., the surveyor observed unlicensed personnel (ULP)-B take R3's blood pressure and administer a medication to R3. R3's record included an Assisted Living with Dementia Care Contract, signed by R3 on September 1, 2022. R2's and R3's assisted living contracts, in the description of policies related to medical assistance waivers, the contract lacked a statement whether the facility required the resident to pay privately for a period of time and the length of time. On November 23, 2022, at 9:23 a.m., regional director/licensed practical nurse (RD/LPN)-D said residents' contracts did not include a statement	0 940		

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0 940	Continued From page 55 whether residents had to pay privately for a period of time. RD/LPN-D stated the facility did not have any restriction like that and all residents had the same contract agreement. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 940		
0 950 SS=E	144.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the	0 950		

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0 950	Continued From page 56 right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to document on the assisted living contract that a resident declined to name a designated representative for two of three 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 service and care plan, each dated September 1, 2022, indicated services included: medication management (with four times daily medication administration), weekly showers with standby assist of 1 staff, monitoring of weight and blood pressure and treatment of TED (thrombi-embolytic deterrent) hose application and removal. On November 22, 2022, at 3:33 p.m. the surveyor observed R2 independently ambulate using a front-wheeled walker and took a seat in a recliner chair in her room.	0 950		

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0 950	Continued From page 57 R2's Assisted Living with Dementia Care Contract, signed by R2 and the facility on September 1, 2022, included the "Right to Designate a Representative for Certain Purposes" form, with the required language. R2's agreement did not list a designated representative, and the box to initial, if resident declined to name a designated representative, was left blank. R3 R3's service plan, dated September 1, 2022, indicated services included: medication management, daily medication administration, weekly showers and monitoring of weight and blood pressure. On November 22, 2022, at 2:39 p.m., the surveyor observed ULP-B obtain R3's blood pressure and administer R3's afternoon medication. R3's Assisted Living with Dementia Care Contract, signed by R3 and the facility on September 1, 2022., included the "Right to Designate a Representative for Certain Purposes" form, with the required language. R3's agreement did not list a designated representative, and the box to initial, if resident declined to name a designated representative, was left blank. On November 23, 2022, at 9:37 a.m., regional director/licensed practical nurse (RD/LPN)-D said the RNs (registered nurses) who complete resident admissions were responsible to get the required signatures and in case of R2 and R3 not listing a designated representative, "it got missed." RD/LPN-D stated the box should either be initialed or a representative name in the	0 950		

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0 950	Continued From page 58 contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950		
0 970 SS=C	144.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident for two of two residents (R2, R3). 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 potential to affect a large portion or all of the residents). The findings include:	0 970		

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0 970	Continued From page 59 R2 R2 was admitted for services on September 1, 2022 R2's Assisted Living with Dementia Care Contract was signed by R2 and the facility on September 1, 2022. R3 R3 was admitted for services on September 1, 2022 R3's Assisted Living with Dementia Care Contract was signed by R3 and the facility on September 1, 2022. R2's and R3's assisted living contracts included two clauses that indicated the resident would waive the facility's liability for health, safety, or personal property of a resident. On page 17, section "2. Indemnification," the contract indicated: Resident will indemnify and hold harmless Provider, its employees and agents from and against any and all claims, actions, damages and liability and expense in connection with loss of life, personal injury or damage to property, arising from or out of the use by resident of the rented premises or any other part of the landlord's property, or caused wholly or in part by an act or omission of resident or resident's guests or agents. On November 23, 2022, at 9:23 a.m., regional director/licensed practical nurse (RD/LPN)-D said the facility had an updated contract from their attorneys that included changes regarding the liabilities. RD/LPN-D said the person in charge at this facility did not take action and new contracts had not gone out to the residents yet. RD/LPN-D	0 970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24431	A. BUILDING: _____ B. WING _____	11/23/2022

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0 970	Continued From page 60 added that all residents had the same contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed ensure a cleared background study had been submitted and received for one of one employee, unlicensed personnel (ULP)-B. In addition, the licensee failed to affiliate background studies for the facility license for 2 of 2 staff, regional director/licensed practical nurse (RD/LPN)-D, and community coordinator (CC)-A. This practice resulted in a level three violation (a violation that harmed a resident's health or safety,	01290		

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	24431	A. BUILDING: _____ B. WING _____	11/23/2022

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01290	Continued From page 61 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). This resulted in an immediate order for correction on November 23, 2022. The findings include: NO BACKGROUND STUDY ON FILE ULP-B ULP-B was hired on January 23, 2021, to provide assisted living services to the licensee's residents on August 1, 2021. ULP-B's employee record contained a background study submitted by a separate location operated by the licensee, dated January 25, 2021. ULP-B's employee record lacked evidence the licensee submitted a background study for their license. On November 22, 2022, at 4:27 p.m., the surveyor observed ULP-B administer afternoon medication to R4. NON-AFFILIATED BACKGROUND STUDIES RD/LPN-D RD/LPN-D was hired on September 26, 2016, under the licensee's former comprehensive home care license and began providing assisted living services to the licensee's residents on August 1, 2021. RD/LPN-D's employee record contained a background study submitted by a separate	01290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24431	A. BUILDING: _____ B. WING _____	11/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01290	Continued From page 62	01290		

location operated by the licensee, dated July 14, 2021. RD/LPN-D's employee record lacked evidence the licensee submitted a background study for their license or affiliated the background study with this license.

CC-A
CC-A was hired on December 10, 2018, under the licensee's former comprehensive home care license and began providing assisted living services to the licensee's residents on August 1, 2021.

CC-A's employee record contained a background study submitted by a separate location operated by the licensee, dated October 19, 2021. CC-A's employee record lacked evidence the licensee submitted a background study for their license or affiliated the background study with this license.

ULP-B, RD/LPN-D, and CC-A's employee records lacked evidence of cleared background studies, affiliated with the licensee's current assisted living with dementia care license, effective August 1, 2021.

On November 23, 2022, at 8:13 a.m., RD/LPN-D stated herself and assisted regional director (ARD)-H do the background studies. RD/LPN-D stated currently they [facility] "just" run a background study for "the one" location, adding they [facility] are in the process of changing the current practice.

On November 23, 2022, at approximately 9:20 a.m., the surveyor verified through Department of Human Services NetStudy 2.0 the following:
- There was no cleared background study or pending application in NetStudy 2.0 for RD/LPN-D, ULP-B or CC-A under the licensee's

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	24431	A. BUILDING: _____ B. WING _____	11/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01290	Continued From page 63 name or license number. The licensee's undated Background Check policy indicated employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. It is the policy of the facility to conduct background checks on all employees and volunteers who will be in direct contact with clients. On November 23, 2022, at 1:22 p.m., the surveyor informed owner/agent (OA)-E of the immediate correction order for lack of cleared and/or affiliated background studies for this license for employees ULP-B RD/LPN-D and CC-A. The employees either needed to be immediately removed from the schedule or be closely supervised by an employee with a cleared background study at all times. The surveyor informed OA-E this would need to be the case until ULP-B, RD/LPN-D, and CC-A's background studies were cleared and affiliated with the licensee's current license No further information was provided. TIME PERIOD FOR CORRECTION: Immediate As of the time of exit on November 23, 2022, immediacy was not removed.	01290		
01370 SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following:	01370		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24431	A. BUILDING: _____ B. WING _____	11/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01370	Continued From page 64 (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview and record	01370		

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01370	Continued From page 65 review, the licensee failed to ensure one of two unlicensed personnel (ULP)-B received the required training/competency testing. 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: ULP-B started employment January 23, 2021, and began providing direct care and assisted living services for the licensee's residents on August 1, 2021. On November 22, 2022, at 2:39 p.m., the surveyor observed ULP-B take R3's blood pressure and administer a medication to R3. ULP-B's employee record lacked evidence of demonstrated competency in the following areas: - appropriate and safe techniques in personal hygiene and grooming, including*: (i) hair care and bathing*; (ii) care of teeth, gums, and oral prosthetic devices*; (iii) care and use of hearing aids*; and (iv) dressing and assisting with toileting*; - standby assistance techniques and how to perform them*; (Skill areas requiring demonstrated competency are denoted with *). On November 23, 2022, at 10:10 a.m., regional	01370		

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	24431	A. BUILDING: _____ B. WING _____	11/23/2022

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01370	Continued From page 66 director/licensed practical nurse (RD/LPN)-D stated training for the unlicensed staff should all be in their files. RD/LPN-D stated skill competencies should be all checked off by the RN (registered nurse) and said she did not know why [ULP-B] does not have these records in her employee file, or if the training had been completed. The licensee's Staff Competency policy, dated August 1, 2021, indicated all residents will receive quality service delivered by staff who are educated and competent in the delivery of home care services. The policy indicated training and competency evaluations for all unlicensed personnel would include the items listed above and ULP may not work until they have successfully passed the written competency and demonstration competency evaluations. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01380 SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident;	01380		

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	24431	A. BUILDING: _____ B. WING _____	11/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01380	Continued From page 67 (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure one of two unlicensed personnel (ULP)-B received the required training/competency testing. 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: ULP-B started employment January 23, 2021, and began providing direct care and assisted living services for the licensee's residents on August 1, 2021. On November 22, 2022, at 2:39 p.m., the surveyor observed ULP-B take R3's blood pressure and administer a medication to R3. ULP-B's employee record lacked evidence of demonstrated competency in the following areas: -observing, reporting and documenting of client status; -basic knowledge of body functioning and	01380		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24431	A. BUILDING: _____ B. WING _____	11/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01380	Continued From page 68 changes in body function injuries, or other observed changes that must be reported to appropriate personnel; -reading and recording temperature, pulse, and respirations of the resident*; -safe transfer techniques and ambulation *; and -range of motion and positioning*. (Skill areas requiring demonstrated competency are denoted with *) On November 23, 2022, at 10:10 a.m., regional director/licensed practical nurse (RD/LPN)-D stated training for the unlicensed staff should all be in their files. RD/LPN-D stated skill competencies should be all checked off by the RN (registered nurse) and said she did not know why [ULP-B] does not have these records in her employee file, and if the training had been completed. The licensee's Staff Competency policy, dated August 1, 2021, indicated all residents will received quality service delivered by staff who are educated and competent in the delivery of home care services. The policy indicated training and competency evaluations for all unlicensed personnel would include the items listed above and ULP may not work until they have successfully passed the written competency and demonstration competency evaluations. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
01470 SS=D	144G.63 Subd. 2 Content of required orientation	01470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24431	A. BUILDING: _____ B. WING _____	11/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCANDIA CAPITAL PARTNERS LLC	101 NORTH 58TH AVENUE WEST DULUTH, MN 55807

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01470	Continued From page 69 (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 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	01470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24431	A. BUILDING: _____ B. WING _____	11/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01470	Continued From page 70 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 one of three employees, unlicensed personnel (ULP)-B received orientation to assisted living facility licensing requirements and regulations with all required content. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: ULP-B started employment January 23, 2021, and began providing direct care and assisted living services for the licensee's residents on	01470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24431	A. BUILDING: _____ B. WING _____	11/23/2022

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01470	Continued From page 71 August 1, 2021. On November 22, 2022, at 2:39 p.m., the surveyor observed ULP-B take R3's blood pressure and administer a medication to R3. ULP-B's training records lacked evidence to indicate the employee had received orientation to include the following topics: -an overview of chapter 144G; -an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; -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; -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 -a review of the types of assisted living services the employee will be providing and the facility's category of licensure. On November 23, 2022, at 10:42 a.m., regional director/licensed practical nurse (RD/LPN)-D stated the required orientation to assisted living had been assigned online, however, ULP-B had not completed the assigned orientation.	01470		

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	24431	A. BUILDING: _____ B. WING _____	11/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01470	Continued From page 72 RD/LPN-D said the licensee had older employees (hired and working prior to the new licensure August 1, 2021) who were to have training on the new requirements and ULP-B should have that in her file. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
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 observation, interview and record review, the licensee failed to ensure staff completed the required amount of dementia care training in the required time frame for one of three	01540		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24431	A. BUILDING: _____ B. WING _____	11/23/2022

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01540	Continued From page 73 employees, unlicensed personnel (ULP)-B. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: The licensee held an Assisted Living with Dementia Care license issued August 1, 2022. ULP-B started employment January 23, 2021, and began providing direct care and assisted living services for the licensee's residents on August 1, 2021. On November 22, 2022, at 2:39 p.m., the surveyor observed ULP-B take R3's blood pressure and administer a medication to R3. ULP-B's employee record indicated the employee had 0 hours (of 8 hours required) of initial dementia training and and 0 hours (of at least 2 required hour) of annual training in dementia care. On November 23, 2022, at 9:50 a.m., regional director/licensed practical nurse (RD/LPN)-D said the facility required 10 hours of dementia training when onboarding staff and staff were required to have two hours of dementia training annually. RD/LPN-D said staff should have that in their file and did not know why ULP-B did not.	01540		

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	24431	A. BUILDING: _____ B. WING _____	11/23/2022

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01540	Continued From page 74 The licensee's Dementia Education policy, dated August 1, 2021, indicated all staff providing assisted living services to residents will be knowledgeable in how to provide safe, effective services related to dementia. The policy indicated direct care employees must have completed at least four (4) hours of initial education within 160 working hours of employee's start date, and at least two (2) hours of education for each twelve (12) months of employment there after. Assisted living statues, effective August 1, 2021, required direct-care staff of facilities licensed as assisted living with dementia care to complete eight (8) hours of initial dementia-care training within 80 hours of employment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01540		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted 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	01620		

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01620	Continued From page 75 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 ensure a registered nurse (RN) conducted assessments with a uniform tool that included all required assessment area content for two of two residents (R2, R3). Also, the licensee failed to ensure ongoing resident monitoring and reassessment was completed 14 calendar days from the initial assessment for two of two residents (R2, R3). In addition, the licensee failed to ensure a change of condition assessment was completed 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) 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: UNIFORM ASSESSMENT TOOL WITH REQUIRED CONTENT	01620		

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01620	Continued From page 76 R2 R2's diagnoses included hyperthyroidism, hyperlipidemia, hypertension (HTN) and congestive heart failure (CHF-condition in which the heart's function as a pump is inadequate to meet the body's needs). R2's admission assessment was dated September 1, 2022. On November 22, 2022, at 3:33 p.m., the surveyor observed R2 independently ambulate using a front-wheeled walker and took a seat in a recliner chair in her room. R2 was wearing compression stockings. R3 R3's diagnoses included CHF, HTN, presence of cardiac pacemaker, presence of automatic implantable cardiac defibrillator. R3's admission assessment was dated September 1, 2022. On November 22, 2022, at 2:39 p.m., the surveyor observed unlicensed personnel (ULP)-B obtain R3's blood pressure and administer R3's afternoon medication. R2's and R3's initial admission assessment forms both dated September 1, 2022, lacked the following required assessment content: -the resident's personal lifestyle preferences, including: sleep schedule, and any other customary routine that is important to the resident's quality of life; -advance health care directives and end-of-life preferences, including whether a person has or wants to seek a "do not resuscitate" order and "do not attempt resuscitation order" or	01620		

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01620	Continued From page 77 "physician/provider orders for life-sustaining treatment" order; -activities of daily living, including: dental status, oral care, and assistive devices and dentures, if applicable; -instrumental activities of daily living, including: housework and laundry; and transportation; -physical health status, including: allergies and sensitivities related to medication, seasonality, environment, and if any of the allergies or sensitivities are life threatening; infectious conditions; a review of medications according to Minnesota Statutes, section 144G.71, subdivision 2, including prescriptions, over-the-counter medications, and supplements, and for each: (1) the reason taken; (2) any side effects, contraindications, allergic or adverse reactions, and actions to address these issues; (3) the dosage; (4) the frequency of use; (5) the route administered or taken; (6) any difficulties the resident faces in taking the medication; (7) whether the resident self administers the medication; (8) the resident's preferences in how to take medication; (9) interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications; and -provide instructions to the resident and resident's legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications; -a review of any reports from a physical therapist, occupational therapist, speech therapist, or cognitive evaluations within the last 12 months;	01620		

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01620	Continued From page 78 -pain, including: location, frequency, intensity, and duration; and effectiveness of medication and non medication alternatives; -nutritional and hydration status and preferences; -list of treatments, including type, frequency, and level of assistance needed; -nursing needs, including potential to receive nursing-delegated services; -risk indicators, including: (1) emergency evacuation ability; (2) complex medication regimen; (3) risk for dehydration, including history of urinary tract infections and current fluid intake pattern; (4) unsuccessful prior placements; (5) elopement risk including history or previous elopements; (6) alcohol and drug use, including the resident's alcohol use or drug use not prescribed by a physician; -who has decision-making authority for the resident, including: -the presence of any advance health care directive or other legal document that establishes a substitute decision maker; and -the scope of decision-making authority of a substitute decision maker under subitem; and -the need for follow-up referrals for additional medical or cognitive care by health professionals. On November 23, 2022, at 10:45 a.m., regional director/licensed practical nurse (RD/LPN)-D stated the facility used the same assessment form for all residents. As to the content of the assessment, RD/LPN-D would have to check to see if another assessment form was used or if there was an updated one but was not aware of a new or updated form. 14 DAY ASSESSMENTS	01620		

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01620	Continued From page 79 R2 R2 was admitted to the assisted living facility on September 1, 2022. R2's service and care plan, each dated September 1, 2022, indicated services included: medication management (with four times daily medication administration), weekly showers with standby assist of 1 staff, monitoring of weight and blood pressure (BP), and compression stockings (TEDs) application and removal. R2's record included an initial assessment completed September 1, 2022, but lacked documentation an RN completed a 14-day re-assessment of R2. R3 R3 was admitted to the assisted living facility on September 1, 2022. R3's service and care plan, each dated September 1, 2022, indicated services included: medication management (with five times daily medication administration), weekly showers with standby assist of 1 staff, monitoring of weight, BP and pulse. R3's record included an initial assessment completed September 1, 2022, but lacked documentation an RN completed a 14-day re-assessment of R3. On November 23, 2022, at 10:45 a.m., RD/LPN-D stated the 14-day assessments for R2 and R3 should have been completed by the RN. RD/LPN-D said if there were no assessments in the charts, it was likely the assessments were not completed as required. RD/LPN-D added she	01620		

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01620	Continued From page 80 would like to reach out to the prior RN to inquire about assessments. CHANGE OF CONDITION ASSESSMENT R3's prescriber's order dated November 21, 2022, included "Healing well since ablation [the removal or destruction of something from an object], Sob (shortness of breath) with exertion and heart logic elevated on device which indicated possible volume overload. Take additional torsemide (used to help treat fluid retention (edema) and swelling that is caused by congestive heart failure) 10 milligrams (mg) this afternoon and an additional tomorrow afternoon if blood pressure allows. Do not admin if SBP (systolic blood pressure/phase of the heart when working/contracting) less 100 mmHg [represents a millimeter of mercury]. Continue other meds without change." R3's record lacked documentation a change of condition assessment was completed after the above procedure. On November 23, 2022, at 10:49 a.m., RD/LPN-D stated "absolutely" a change of condition assessment should have been completed for R3 after having a procedure done, adding R3 was in a weakened state. The licensee's Assessment - Comprehensive Services policy, dated August 1, 2021, indicated an individualized initial evaluation of all new clients shall be completed on admission by a registered nurse in order to develop a personalized service plan. The policy contained outdated language and indicated the initial assessment must be completed within five (5) days of the initial of services. The policy indicated	01620		

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01620	Continued From page 81 the RN will provide a reassessment visit to update the evaluation of the client and services no more than 14 days after initiation of services. In addition, the policy stated ongoing client monitoring and reassessment must be conducted as needed based on changes in the needs of the client but cannot exceed 90 days from the last date of assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
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. (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.	01640		

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01640	Continued From page 82 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure a current written service plan was finalized no later than 14 calendar days after the date that services were first provided, for one of three residents (R9). 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: R9 was admitted on November 14, 2022, and received services under the licensee's assisted living with dementia care license. R9's diagnoses included congestive heart failure (CHF- condition in which the heart's function as a pump is inadequate to meet the body's needs), depression, and edema. R9's Care Plan dated November 2022, indicated R9 required total assist with bath/shower one day a week or more as needed (prn), assist with dressing in the morning and evening, 1 staff to supervise/assist for safety in ambulation 10 times a day, and 1 staff to supervise/assist with toileting every 2 hours (10 times per day). R9's Medication Management Plan: Addendum to	01640		

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01640	Continued From page 83 Service Plan, dated November 14, 2022, indicated R9 required assistance with medication administration. R9's Treatment Plan: Addendum to Service Plan, November 14, 2022, indicated R9 required assistance with compression stockings (TEDs), creams, and staff to set up C-pap [noninvasive ventilation breathing support through a face mask, nasal mask, or helmet]. On November 22, 2022, at 7:17 a.m., the surveyor observed unlicensed personnel (ULP)-B administer R9's morning medication, obtain weight, administer eye drops, apply topical cream to lower legs, and apply TEDs. R9's record lacked a service plan. On November 23, 2022, at approximately 1:40 p.m., regional director/licensed practical nurse (RD/LPN)-D reviewed R9's record with surveyor. In the front of R9's record was a check list of tasks to be completed at the time of admission. The service plan task had not been marked as completed, all other tasks had been marked as completed. RD/LPN-D stated R9's service plan had not been completed as required. The licensee's Service Plans policy dated May 9, 2019, indicated beginning with the initiation of services, a service plan was developed for the client based on an agreement with the client/responsible party and on the assessed needs identified in the comprehensive assessment. The service plan would be finalized no later than 14 days after the initiation of services, if not already completed. No further information was provided.	01640		

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01640	Continued From page 84 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 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	01650		

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01650	Continued From page 85 review, the licensee failed to ensure the service plan included the required content for two of two residents (R2, R3). This had the potential to affect all nine (9) residents who received services at the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2 R2's diagnoses included hyperthyroidism, hyperlipidemia (high cholesterol), hypertension (HTN-high blood pressure), and congestive heart failure (CHF-condition in which the heart's function as a pump is inadequate to meet the body's needs). R2's service and care plan, each dated September 1, 2022, indicated services included: medication management (with four times daily medication administration), weekly showers with standby assist of 1 staff, monitoring of weight and blood pressure (BP), and treatment of compression stockings (TEDs) application and removal. R2's Service Plan lacked the following required content: - the method of monitoring staff providing services. R3	01650		

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01650	Continued From page 86 R3's diagnoses included congestive heart failure CHF, HTN, chonic kidney disease, presence of cardiac pacemaker, and presence of automatic implantable cardiac defibrillator. R3's service and care plan, each dated September 1, 2022, indicated services included: medication management (with five times daily medication administration), weekly showers with standby assist of 1 staff, monitoring of weight, BP and pulse. On November 22, 2022, at 2:39 p.m., the surveyor observed unlicensed personnel (ULP)-B obtain R3's blood pressure and administer R3's afternoon medication. R3's Service Plan lacked the following required content: - the methods of monitoring staff providing services. On November 23, 2022, at 10:42 a.m., regional director/licensed practical nurse (RD/LPN)-D stated R2 and R3's service plans were incomplete and did not include the above noted content. RD/LPN-D stated all the service plans would be missing the above-mentioned required content. The licensee's Service Plans policy dated May 9, 2019, indicated the service plan included: -a description of the home care services to be provided; the service description may be in the form of the client's care plan developed with the client/responsible party; -the fees for services and the frequency of each service, according to the client's current review or assessment and client preferences; -the identification of the staff or categories of staff	01650		

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01650	Continued From page 87 who would provide the services; -the schedule and methods of monitoring review of assessments of the client; -the frequency of sessions of supervision of staff and type of personnel who would supervise staff; and -a contingency plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
01750 SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) prepared in writing specific instructions for each resident and documented those instructions for one of two residents (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01750		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24431	A. BUILDING: _____ B. WING _____	11/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCANDIA CAPITAL PARTNERS LLC	101 NORTH 58TH AVENUE WEST DULUTH, MN 55807

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01750	Continued From page 88 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: R4's diagnoses included diabetes, chronic kidney disease (CKD- (mild to moderate damage, kidneys are less able to filter waste and fluid out of blood) and hypertension (HTN-high blood pressure). R4's Assessment For Need For Medication Reminders, Assistance, Administration or Central Storage dated December 14, 2021, indicated "resident alert and orientated, normal hand dexterity, vision adequate. Resident is appropriate to self administer meds after staff set up and meds are brought to her at appropriate times." R4's prescriber's orders dated May 16, 2022, included an order to decrease furosemide to 40 milligrams (mg) daily and to monitor for increase in lower extremities (LE) edema. R4's November 1, 2022, through November 21, 2022, medication administration record (MAR) included: furosemide (fluid retention) 40 mg tablet, take 1 tablet by mouth once daily. On November 21, 2022, at 3:50 p.m., community coordinator (CC)-A stated R4's MAR lacked instructions for monitoring of LE edema. On November 22, 2022, at 4:27 p.m., the	01750		

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01750	Continued From page 89 surveyor observed unlicensed personnel (ULP)-B administer R4's scheduled afternoon medication. The licensee's Physician's Orders policy dated August 1, 2021, indicated the registered nurse was responsible for implementing medication and treatment orders or for delegating the orders to the appropriate paraprofessional. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01760 SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered as ordered for two of two residents (R3, R4). The licensee also failed to ensure documentation of medication	01760		

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01760	Continued From page 90 administration was completed for two of two residents (R3, R9). In addition, the licensee failed to ensure the steps of the medication administration process was followed for two of two employees unlicensed personnel (ULP)-B, ULP-J. 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 finding include: FAILURE TO ADMINISTER MEDICATIONS PER ORDER R3 Vitamin B12 R3's diagnoses included congestive heart failure (CHF-condition in which the heart's function as a pump is inadequate to meet the body's needs), hypertension (HTN), presence of cardiac pacemaker, presence of automatic implantable cardiac defibrillator. R3's Medication Assessment dated September 1, 2022, indicated R3 required medication administration. On November 22, 2022, at 2:39 p.m., the surveyor observed ULP-B take R3's blood pressure and administer torsemide (fluid retention) 10 milligram (mg) to R3.	01760		

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01760	Continued From page 91 R3's prescriber's order dated September 28, 2022, included cyanocobalamin (B-12 injection, intramuscular (IM) injection to treat vitamin B12 deficiency) 1000 micrograms (mcg/milliliter (ml) solution, inject 1000 mcg every 30 days, use once daily on the 14th of every month. R3's prescriber's order dated October 26, 2022, included "okay to give Vitamin B-12 injection once monthly." R3's MARs (medication administration record) dated September 1, 2022, through November 21, 2022, failed to include vitamin B12 1000 mcg on the MAR. On November 21, 2022, at 1:51 p.m., CC-A stated she had questioned a nurse about R3's B-12 medication and CC-A stated she was told she should give the injection. CC-A stated she had been instructed "to give like insulin" and CC-A pointed to areas that the injection could be given, subcutaneous sites. CC-A added she was not comfortable administrating the B12 injection and stated she did not administer the B12 medication. CC-A added B-12 "use to be" on the MAR however it was no longer on the MAR. On November 23, 2022, at approximately 11:00 a.m., regional director/licensed practical nurse RD/LPN-D stated she would investigate the vitamin B12 order. RD/LPN-D stated the medication had not been administrated if it was not listed on the MAR. RD/LPN-D added CC-A should not have been told she should have given the vitamin B-12 IM injection, the nurse should have given it. Colchicine R3's MAR dated November 1, 2022, through	01760		

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01760	Continued From page 92 November 21, 2022, included colchicine (inflammation and pain) 0.6 mg tablet take 0.3 mg (½ tab) tablet by mouth 2 times a daily for 7 days, start on November 10, 2022, through November 16, 2022. R3's after visit summary (AVS) dated November 9, 2022," included "We will start colchicine 0.3 milligrams (mg) twice daily for 14 days. This will help with chest discomfort" and "Start taking these medications, colchicine 0.6 mg, take 0.5 tablets by mouth two times a day for seven days." In addition, R3's AVS was not physically or electronically signed by prescriber. On November 23, 2022, at approximately 10:55 a.m., RD/LPN-D stated R3's AVS was used as an order adding clarification had not been sought for R3's colchicine 0.3 mg order to determine duration for 7 or 14 days. Torsemide R3's prescriber's order dated November 21, 2022, included take additional torsemide 10 mg this afternoon and an additional tomorrow afternoon if blood pressure allows. Do not administer if systolic blood pressure less than 100 mm hg [represents a millimeter of mercury]. On November 21, 2022, at approximately 2:00 p.m., CC-A looked at the new order R3 received and stated she would fax it to RD/LPN-D. On November 21, 2022, at 2:56 p.m., a one paged MAR was faxed to the site with R3's name on it. The entry on the MAR included, torsemide 10 mg, give an additional torsemide 10 mg by mouth this afternoon and an additional torsemide 10 mg tomorrow afternoon if blood pressure allows, do not administer if systolic blood	01760		

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	24431	A. BUILDING: _____ B. WING _____	11/23/2022

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01760	Continued From page 93 pressure less than 100 mm hg. On November 21, 2022, at 2:57 p.m., ULP-B looked at the fax and stated "it" [MAR] was incorrect as the times were wrong. On November 21, 2022, at approximately 3:10 p.m., ULP-B called RD/LPN-D and made her aware of her concerns with R3's MAR. RD/LPN-D stated she was on her way to the dentist, and she would fix it (MAR) and fax it back. On November 22, 2022, at approximately 10:00 a.m., ULP-B stated R3 did not have an additional torsemide 10 mg tablet on November 21, 2022. ULP-B stated she did not hear back from RD/LPN-D. On November 23, 2022, at approximately 10:55 a.m., RD/LPN-D stated R3's medication error [no additional torsemide] was "all hers," adding R3's additional torsemide 10 mg order had not been followed as ordered. R4 R4's diagnoses include diabetes, and HTN. R4's Medication Management Plan: Addendum to Service Plan dated November 14, 2022, indicated R4 required medication administration daily. R4's prescriber's order dated May 16, 2022, included an order for psyllium husk 0.4 gram capsule, 1.2 grams (3 0.4 gram) capsules daily. R4's November 1, 2022, through November 21, 2022, MAR included: "daily fiber capsule, Metamucil capsule, take 3 capsules by mouth every morning with 8 ounces of water." R4's MAR indicated daily fiber capsules were given at 8 a.m.	01760		

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01760	Continued From page 94 (morning) 18 out of the 21 opportunities, and at 8 p.m. (evening) 19 out of 21 opportunities. On November 22, 2022, at 4:27 p.m., the surveyor observed R4 request "2 of her brown pills" adding she (R4) had diarrhea again. ULP-B checked R4's MAR and removed R4's scheduled Xarelto 20 mg (blood thinner) and documented on the MAR a "dot" to indicate the medication had been prepared. ULP-B removed 2 daily fiber capsules and added them to the medication cup. ULP-B went to mark the MAR, for medication R4 had requested ("2 brown pills" fiber capsules). ULP-B's pen hovered over the loperamide (loose stools) line on the MAR. The surveyor inquired about the medications in R4's medication cup. ULP-B stated R4 had said she could take 2 of the brown pills PRN in addition to the 3 pills taken every am. ULP-B stated, "this is what we have been giving her, she thinks it helps her." On November 22, 2022, directly following the above observation ULP-B stated the MAR was incorrect adding the medication was to be given one time a day and PRN. On November 23, 2022, at 4:00 p.m., RD/LPN-D was in the process of seeking a clarification order for R3's colchicine 0.3 mg order and R4's fiber capsules. RD/LPN-D added she received the pharmacy's order for the prn fiber capsules. MEDICATION DOCUMENTATION R3's record lacked documentation verifying R3 received the following scheduled services from November 11, 2022, through November 21, 2022; -1 of 21 opportunities for amiodarone 200 mg (a-fib): -2 of 20 opportunities for atorvastatin 40 mg	01760		

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01760	Continued From page 95 (cholesterol); -4 of 41 opportunities for bupropion 200 mg (depression) -1 of 1 opportunities for calcium/d 500/200 mg (supplement); and -1 of 3 opportunities for methotrexate 2.5 mg (breast cancer) R9 R9's record lacked documentation verification R9 received the following medications from November 14, 2022, through November 22, 2022; -2 of 7 opportunities for Eliquis 5 milligram (mg) (blood thinner); -5 of 22 opportunities for Bion tears (dry eyes); -2 of 7 opportunities for cetirizine 5 mg (allergies) -4 of 22 opportunities for diclofenac 1% gel (pain) -1 of 7 opportunities for escitalopram 10 mg (depression); -1 of 7 opportunities for famotidine 20 mg (heart burn); -1 of 7 opportunities for levothroxine 150 micrograms (mcg) (thyroid); -2 of 7 opportunities for oyster shell 500 mg (supplement); -2 of 7 opportunities for multi vit (supplement); -6 of 14 opportunities for potassium chloride (supplement); -2 of 7 opportunities for pramoxine 10 mg (heart failure); -1 of 7 opportunities for spironolactone 25 mg (edema); -2 of 15 opportunities for torsemide 20 mg; and -2 of 15 opportunities for tramadol 50 mg (pain). On November 21, 2022, at 1:44 p.m., CC-A stated R9 and R3's records were lacking documentation of services provided and medication administration. CC-A stated if medications were missed the counts would be	01760		

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01760	Continued From page 96 off, the cycled medication cards would not be correct. STEPS OF THE MEDICATION ADMINISTRATION PROCESS ULP-B ULP-B began employment January 23, 2021, and began providing direct care and assisted living services for the licensee's residents on August 1, 2021. On November 21, 2022, at 12:01 p.m., the surveyor observed ULP-B administer three medications to R9. ULP-B did not document after R9's medication was administered. ULP-B stated, "I signed it [medication] out before I gave it [medications], adding "most of the time" I "dot it" (the medication administration record) first to indicate the medications had been removed for administration. On November 21, 2022, at approximately 1:44 p.m., CC-A stated medications should be signed out after administration. ULP-J ULP-J began providing direct care and assisted living services for the licensee's residents on June 29, 2022. On November 23, 2022, at 7:51 am., the surveyor observed ULP-J take medications to R5. ULP-J left R5's room and went to the kitchen and filled up R5's glass with ice and water. ULP-J took the filled glass back to R5 and returned to the kitchen. ULP-J put on gloves and went to the freezer to get breakfast started for R7. R5's 90-day assessment dated March 1, 2022,	01760		

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01760	Continued From page 97 included "staff administers all medications to her [R5] at the prescribed times She is able to self-administer medications after staff sets them up and brings them to her." On November 23, 2022, directly following the above observation ULP-J stated she did not document medication administration for R5 since R7 was hungry. ULP-J added she would document after she assisted R7. On November 23, 2022, at 12:19 p.m., RD/LPN-D stated staff were not documenting on the MARs as directed. RD/LPN-D confirmed medications are to document directly after administration. The licensee's undated Medication Administration for the Home Health Aide policy indicated the clinical record, including the MAR, is a legal document and must be correctly completed. Document the medication administration immediately AFTER giving the medications. It is extremely easy to get busy and forget to document and then it is not known later if the medication was missed. The licensee's Physician's orders policy dated August 1, 2021, indicated written orders from an authorized prescriber would be obtained for all medications and treatments with which the home health agency assists clients, including over the counter medication. In addition, the registered nurse was responsible for implementing medication and treatment orders or for delegating the orders to the appropriate paraprofessional. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	01760		

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01760	Continued From page 98 days	01760		
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to	01790		

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01790	Continued From page 99 be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure one of one unlicensed personnel (ULP-B) was trained and had demonstrated competency to prepare and give medications for residents having unplanned time away. 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	01790		

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01790	Continued From page 100 of the residents). The findings include: ULP-B was hired on January 23, 2021, under the licensee's former comprehensive home care license and began providing assisted living services to the licensee's residents on August 1, 2021. On November 22, 2022, at 2:39 p.m., the surveyor observed ULP-B take R3's blood pressure and administer R3's afternoon medication. ULP-B's employee record lacked evidence to indicate she had been trained and had demonstrated competency to provide medications to residents for unplanned times away from home. On November 23, 2022, at 12:25 p.m., regional director/licensed practical nurse (RD/LPN)-D confirmed ULP-B's employee record did not contain evidence of training and competency to prepare and give medication for residents having unplanned time away. RD/LPN-D added she was "not sure if she [ULP-B] even did it [unplanned time away training]". The surveyor requested ULP-J's unplanned time away training from RD/LPN-D. RD/LPN-D did not provide ULP-J's unplanned time way training. The licensee's Medication Management Plan for Clients Away from Home dated February 7, 2019, indicated the registered nurse may delegate an ULP to set up the medications based on the following: -the ULP has documentation of passing a competency evaluation for medication	01790		

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	24431	A. BUILDING: _____ B. WING _____	11/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01790	Continued From page 101 administration; -the RN had instructed the ULP to ensure that all appropriate precautions were taken; and -the ULP may set up not more than a 72-hour supply of the client's medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
01880 SS=D	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure prescription medications were stored in a secured manner allowing only authorized personnel access. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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 for services on January 22,	01880		

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	24431	A. BUILDING: _____ B. WING _____	11/23/2022

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01880	Continued From page 102 2022, and discharged on November 2, 2022. R1's Service Plan dated January 26, 2022, indicated the resident received medication management services which included medication administration. On November 23, 2022, at the surveyor observed a basket on the floor, under a table, in the locked nurses office. The basket obtained several punch out (bubbles) cardboard medication cards (month cycle) for R1. One of the medication cards was labeled "methadone (schedule II drug under the Controlled Substances Act) 5 milligrams tablet, take 0.5 tab at bedtime for control of pain." The card was numbered 1 to 31, with 30 of the medication bubbles having been filled. On the card 23 of the bubbles had been punched out and marked with a date and staff's initials. The medication card contained 7 half tablets of methadone. On November 23, 2022, at 1:34 p.m., regional director/licensed practical nurse (RD/LPN)-D stated the methadone should not have been in the basket, it should have been double locked. On November 23, 2022, at approximately 4:00 p.m., RD/LPN-D removed the methadone for the nurse's office to double locked secured location. The licensee's Storage/Control of Medications policy dated February 7, 2019, indicated when the facility was providing storage of medications outside of the client's private living space, all prescription drugs were securely locked in substantially constructed compartments according to the manufacturer's direction. Only authorized personnel had access to the stored medication. In addition, schedule II controlled	01880		

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	24431	A. BUILDING: _____ B. WING _____	11/23/2022

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01880	Continued From page 103 substances were stored in a separately locked compartment. The registered nurse was responsible for establishing the protocol related to monitoring/securing controlled medications based on the initial assessment and risk of diversion. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=E	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to date time-sensitive medications with an opened or expiration date for two of nine residents (R6, R7). In addition, the licensee failed to monitor for expired medication for one of one resident (R8). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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	01890		

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01890	Continued From page 104 found to be pervasive). On November 21, 2022, at 10:20 a.m., 2022, the surveyor reviewed the medication cart with unlicensed personnel (ULP)-B confirming the following: TIME SENSITIVE MEDICATIONS R6 -opened bottle of latanoprost 0.005% ophthalmic (eye) solution (glaucoma medication) did not have a label which indicated the date the eye drop solution had been opened and when the solution would expire. -opened bottle of dorzol/timolol (glaucoma) 22.3 milligrams (mg) dorzolamide/6.8 mg timolol solution did not have a label which indicated the date the eye drop solution had been opened and when the solution would expire. -opened bottle of brimonidime tartart (glaucoma) 0.15 mg solution did not have a label which indicated the date the eye drop solution had been opened and when the solution would expire. R7 -opened ivrizia dry eye solution did not have a label which indicated the date the eye drop solution had been opened and when the solution would expire. EXPIRED MEDICATION R8 -nitroglycerin (chest pain) 0.4 mg had expired September 2022. The manufacturer's instructions for latanoprost	01890		

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	24431	A. BUILDING: _____ B. WING _____	11/23/2022

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01890	Continued From page 105 eye solution dated October 2019, directed to discard any unused solution after 42 days. The manufacturer's instructions for dorzol/timolol dated October 2022, directed to discard any unused solution after 28 days. The manufacturer's instructions for brimonidime tartart 0.15 mg solution dated December 2014, directed to discard any unused solution 4 weeks after opening. The manufacturer's instructions for ivnizia solution dated September 2021, directed to discard any unused solution after 90 days. The licensee's Storage/Control of Medications policy dated February 7, 2019, indicated medication is labeled completely and legibly. The medication label should contain the following: prescription number and name of medication, strength and quantity, expiration date for time-dated drugs, directions for use, resident's name, prescriber's name, date issues, and name and address of licensed pharmacy issuing the medication. The licensee's Service Plan for Medication Management policy dated February 7, 2019, included the facility had procedures for verifying the prescription medications were administered as prescribed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

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	24431	A. BUILDING: _____ B. WING _____	11/23/2022

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01910	Continued From page 106	01910		
01910 SS=E	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide documentation in the resident's record the disposition of medications, including quantity, for two of two discharged residents (R1, R11). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the	01910		

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01910	Continued From page 107 situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 R1 was admitted for services on January 22, 2022, and discharged on November 2, 2022. R1's Service Plan dated January 26, 2022, indicated the resident received medication management services which included medication administration. R1's prescriber order's dated November 1, 2022, included: ipratropium-albuterol (Duo-Neb: relax and open air passages to the lungs to make breathing easier) 0.5 milligram (mg) - 2.5 mg/3 milliliter (ml) solution , methadone (moderate to severe pain) 0.5 mg at bedtime daily, and some as needed medications. On November 23, 2022, at 12:45 p.m., regional director/licensed practical nurse (RD/LPN)-D stated R1's discharge summary had not been completed as of this time. RD/LPN-D added her expectation was that the discharge summary would be completed "immediately". R11 R11 was admitted for service on June 1, 2021, and was discharged on January 24, 2022. R11's Discharge Summary dated April 29, 2022, included "Status of Medications Upon Discharge: need at time of discharge (1/24/22) Destroyed when terminated contract with facility April 31, 2022." On November 23, 2022, at approximately 4:10	01910		

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	24431	A. BUILDING: _____ B. WING _____	11/23/2022

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01910	Continued From page 108 p.m., RD/LPN-D stated she was unable to find R11's service plan. RD/LPN-D found only the discharge note for R11. RD/LPN-D and community coordinator (CC)-A both were unable to find R11's medication disposition record or any record R11's medications had been destroyed. RD/LPN-D stated she does medication disposition of all medication residents are taking. RD/LPN-D showed the surveyor a blank form/ template she uses. The licensee's Disposition/Disposal of Medication policy dated February 7, 2019, indicated upon disposition, the facility would document the following information in the clinical record: -name, strength and prescription number of medication, as applicable; -quantity; -method of disposition or to whom the medications were given; -date of disposition; and -name(s)/signature(s) of staff involved in disposition. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
01950 SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or	01950		

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	24431	A. BUILDING: _____ B. WING _____	11/23/2022

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01950	Continued From page 109 assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure prior to delegating nursing tasks, the registered nurse (RN) trained unlicensed personnel (ULP) to demonstrate the ability to follow the procedure to perform the tasks for one of one employee (ULP-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: R9's diagnoses included congested heart failure (CHF-condition in which the heart's function as a pump is inadequate to meet the body's needs),	01950		

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	24431	A. BUILDING: _____ B. WING _____	11/23/2022

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01950	Continued From page 110 depression, and edema. R9's prescriber's orders dated November 15, 2022, included compression (TED) stockings, compression wraps for right and left legs, size, large/short. R9's Treatment Plan dated November 14, 2022, included TED socks, apply morning, remove evening. On November 22, 2022, at 7:17 a.m., the surveyor observed ULP-B obtain R9's weight. ULP-B applied topical cream to R9's lower legs. ULP-B applied TED hose to R9's legs. ULP-B pulled the TEDs up and over R9's knees and then folded them down and placed the cuffed edge under R9's knees. ULP-B commented, "I bet you are wondering why I do that. If I don't, they crease "here" [pointing to the back of R9's knees] and pinch." ULP-B confirmed the TEDs were "taller" than R9's lower legs. On November 23, 2022, at 3:52 p.m., regional director/ licensed practical nurse (RD/LPN)-D stated there was no evidence ULP-B had demonstrated the ability to follow the procedure to perform the task of applying TEDs. RD/LPN-D added TEDs should be put on with no wrinkles and if too tall, staff should alert a nurse so a new pair could be obtained, "measure from heel to knee." The licensee's undated Application of Elastic (TED) Stockings procedure indicated staff are to review care plan or instruction sheet regarding use of stockings, wash hands, gather stockings, explain procedure to client, turn elastic stockings inside out, place client's toe into foot of stocking, making sure stocking is smooth. Slide remaining	01950		

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	24431	A. BUILDING: _____ B. WING _____	11/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01950	Continued From page 111 portion of stocking over the client's foot, being sure that toes are covered/stock will be right side out now. Slide stocking over client's calf until it is completely extended. Be sure that stocking is smooth with no ridges. The licensee's Delegation of Assisted Living Services dated August 1, 2021, indicated the RN or other health professional may debate procedures according to the following; -the RN instructed the home health aide in the proper methods to perform the procedure with respect to each client; -the RN provided the home health aide with written instructions specific to the client; -the home heath aide demonstrated to the RN competence in the procedure; -the procedure is documented in the client's clinical record; and -the home health aide's competence is documented in his/her personnel file. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		
01960 SS=E	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24431	A. BUILDING: _____ B. WING _____	11/23/2022

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01960	Continued From page 112 and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure treatment or therapies were administered as directed and failed to document the reason they were not administered, and any follow up procedures provided to meet the resident's needs for two of three residents (R4, 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: R4 R4's diagnoses include diabetes and hypertension (HTN). R4's Medication Management Plan: Addendum to Service Plan dated November 14, 2022, indicated R4 required medication administration daily. R4's record lacked a service plan and treatment plan. R4's prescriber's orders dated November 15, 2022, included: - decrease valsortan (high blood pressure) to 80	01960		

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01960	Continued From page 113 milligrams (mg) once daily; and - check blood pressure a few times weekly and contact provider if findings were less than 100/70 or greater than 140/90. On November 22, 2022, at 4:27 p.m., the surveyor observed unlicensed personnel (ULP)-B administer R4's scheduled afternoon medication. R4's Treatment Record dated November 1, 2022, through November 30, 2022, included: "Check blood pressure (BP) three times weekly, notify MD (medical doctor) if BP is less than 100, less then 70, or greater than 140/ greater 90. Per MD " dated November 15, 2022. R4's Treatment Record, dated November 2022, included boxes drawn around November 16, 18, 21, 23, 25, 28, 30 to indicate BP should be taken those days. R4's Treatment Record for BP monitoring was blank on November 16, 18, or 21. On November 21, 2022, at 3:46 p.m., the surveyor reviewed R4's Treatment Record and prescriber's order with community coordinator (CC)-A. CC- A stated "I don't know why they [ULPs] are not doing it [BP]. It just started." CC-A confirmed R4's BP had not been taken. R4's Monthly Vital Signs flow sheet, dated January 2022, found in R4's binder, which also contained R4's medication administration record (MAR), and R4's Treatment Record included vital signs for the month of January, February, March, April, May, and June. R4's record did not contain vital signs for the month of July, August, September, October, or	01960		

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01960	Continued From page 114 November. On November 23, 2022, at 4:02 p.m., regional director/licensed practical nurse (RD/LPN)-D stated vital signs should be taken weekly, on shower days and documented. RD/LPN-D stated vital signs were not being completed as directed. R3 R3's diagnoses included congestive heart failure (CHF-condition in which the heart's function as a pump is inadequate to meet the body's needs), HTN, presence of cardiac pacemaker, and presence of automatic implantable cardiac defibrillator. R3's Care Plan dated September 2022, found in the front of R3's binder which also included her MAR, included blood pressure, pulse: daily every morning. Weight daily every morning before breakfast. R3's prescriber's orders dated November 9, 2022, included weigh yourself daily for 1-2 weeks and keep a record. Call if weight gain of 2 pounds in a day or 5 pounds in a week. R3's prescriber's order dated November 21, 2022, included, take additional torsemide (used to help treat fluid retention (edema) and swelling that is caused by congestive heart failure) 10 milligrams (mg) this afternoon and an additional tomorrow afternoon if BP allows. Do not admin if SBP (systolic blood pressure/phase of the heart when working/contracting) less 100 mmHg [represents a millimeter of mercury]. On November 22, 2022, at 2:39 p.m., the surveyor observed ULP-B take R3's BP and administer R3's afternoon medication. R3 told	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24431	A. BUILDING: _____ B. WING _____	11/23/2022

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01960	Continued From page 115 ULP-B "you forgot to take it [BP] this morning" as R3 reached out her arm for staff. ULP-B replied, "we were told we did not have to take it anymore." R3's Daily Monitoring Flowsheet dated November 2022, included: -November 9, 2022, BP 134/80, and -November 11, 2022, weight 142.5. R3's Treatment Record dated November 1, 2022, through November 21, 2022, lacked documentation of R3's weight 1 out of 21 opportunities. R3's record lacked daily blood pressure reading. On November 21, 2022, CC-A stated documentation of treatments is not being done as directed. In addition, treatments are not always getting done as ordered. The licensee's Treatment and Therapy Management policy dated May 9, 2019, indicated the facility would use treatment and therapy protocols consistent with current evidence-based practice standards and guidelines. The registered nurse (RN) was responsible for assessing and developing the treatment and/or therapy service plan for clients. When the RN delegates treatments or therapies, the professional would monitor and evaluate its effectiveness on a regular basis as specified in the service plan. Each staff member who administers a treatment or therapy was responsible for documenting this in the clinical record. When a treatment or therapy was not administered as ordered or prescribed, staff would document the reason why it was not administered and any follow-up procedures provided to meet the client's needs.	01960		

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	24431	A. BUILDING: _____ B. WING _____	11/23/2022

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01960	Continued From page 116 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: 2040 Based on observation, interview and record review, the licensee failed to conduct a hazard vulnerability or safety risk assessment on or around the facility property. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all residents).	02040		

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	24431	A. BUILDING: _____ B. WING _____	11/23/2022

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02040	Continued From page 117 The findings include: Survey staff requested a facility hazard vulnerability or safety risk assessment documentation, but the licensee was not able to provide the requested documentation. During interview on November 21, 2022, at 1:00 p.m., the director of maintenance (DM)-I confirmed the findings. No further information provided. 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 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	02110		

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	24431	A. BUILDING: _____ B. WING _____	11/23/2022

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02110	Continued From page 118 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, the licensee failed to ensure policies and procedures required in the licensing of assisted living facilities with dementia care were developed or implemented, and provided to each resident and/or the residents legal and designated representative at the time of move-in. This had the potential to affect all dementia care 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:	02110		

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02110	Continued From page 119 The licensee held an Assisted Living with Dementia Care license issued August 1, 2022. The licensee lacked evidence the following required policies and procedures related to dementia care had been developed or provided to residents, their legal representatives and designated representatives at time of move in: -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; -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. On November 23, 2022, at 12:12 p.m., regional director/licensed practical nurse (RD/LPN)-D said the dementia-care policies were part of the contract and given to resident upon admission. RD/LPN-D thought the disclosure and policies, acknowledged by the residents, satisfied the dementia-care policy requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	02110		

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02110	Continued From page 120 (21) days	02110		
02170 SS=D	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and	02170		

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	24431	A. BUILDING: _____ B. WING _____	11/23/2022

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02170	Continued From page 121 (8) outdoor activities. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to conduct an evaluation for activities that addressed all provisions and failed to develop an individualized activity plan based with required content based on the evaluation, for one of one resident (R5) who received services under an assisted living with dementia care license. 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: R5's diagnoses included aortic arteriosclerosis, heart murmur, hypothyroidism, osteoporosis, dementia and developmental delay. On November 22, 2022, at 6:47 a.m., the surveyor observed R5 lying in bed. R5 reached over and grabbed onto an assistive device (U-type of bar) on her bed, to assist herself into a sitting position. The surveyor observed unlicensed personnel (ULP)-B administer R5's morning medication. R5's 90-day assessment, dated March 1, 2022, identified the resident had glasses and macular degeneration, was alert and oriented to person,	02170		

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02170	Continued From page 122	02170		

place and time, was forgetful and would become upset at times if routine was interrupted. The assessment also indicated R5 liked watching TV shows, visiting, exercise, bingo, visiting with family and sitting outside in nicer weather.

R5's record lacked evidence the resident had been evaluated for activities according to the licensing rules of the facility, to include the following:
- past and current interests
- current abilities and skills
- emotional and social needs and patterns
- physical abilities and limitations
- adaptations necessary for the resident to participate; and
- identification of activities for behavioral interventions

In addition, R5's record lacked the development of an individualized activity plan.

On November 23, 2022, at 12:12 p.m., regional director/licensed practical nurse (RD/LPN)-D said there was an activity evaluation for residents and later provided a form titled "Dementia Activity Assessment Tool." RD/LPN-D did not know who was responsible to complete the form and could not say if it was completed for any of the current residents. With respect to the activity plan, RD/LPN-D referred the surveyor to the dementia information in the resident contract, which she said indicated what activities would be available here. RD/LPN-D did not know if residents had a written activity plan and that the activities listed on the contract dementia information was not individualized for residents.

The surveyor reviewed the facility document "Dementia Activity Assessment Tool," undated,

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02170	Continued From page 123 which contained the activity assessment areas listed above. However, R5's record did not contain a completed dementia activity assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02170		
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the care and services were provided according to acceptable health care and medical care, or nursing standards for two of two residents (R5, R10) with an assistive device (consumer bedrail). 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:	02310		

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02310	Continued From page 124 This resulted in a correction order on November 22, 2022, at approximately 11:30 a.m. R5 On November 22, 2022, at 6:47 a.m., the surveyor observed R5 lying in bed. R5 reached over and grabbed onto an assistive device (U-type of bar) on her bed, to assist herself into a sitting position. The surveyor observed unlicensed personnel (ULP)-B administer R5's morning medication. R5's diagnoses included heart murmur (a whooshing or swishing sound heard through a stethoscope when blood flows abnormally over your heart valves), memory loss/dementia, and chronic neck pain. R5's record lacked a service plan. R5's 90-day assessment dated March 1, 2022, indicated R5 was independent with mobility and had "1 top siderail on bed." R10 R10's diagnoses included macular edema (happens when blood vessels leak into a part of the retina called the macula), arthritis, blindness one eye, spells of confusion with no facial deficits, polyneuropathy (the simultaneous malfunction of many peripheral nerves throughout the body), and TIAs (a brief stroke-like-attack that may be a warning sign of a future stroke). R10's Health Care Service Agreement/Plan of Care dated January 6, 2022, indicated the resident received following services: diabetic foot check with shower 2x/week, fall risk/history of falls ongoing, safety checks every two hours	02310		

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	24431	A. BUILDING: _____ B. WING _____	11/23/2022

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02310	Continued From page 125 medication administration three times a day and as needed. R10's 90 day "reassessment" dated March 28, 2022, indicated R10 had no change with mobility, safety, equipment, siderails: "no changes at this time. Resident remains safe in her bed. Reminded to take all blankets off before getting up, take time to change position." On November 22, 2022, at 7:46 a.m., the surveyor observed R10 sitting in a recliner. The surveyor observed an accordion type of assistive device in the lowered position on R10's unmade bed. R10 stated her brother-in-law brought in the bedrail this summer since she fell out of bed, adding "I don't use it [bedrail]." The surveyor went to the bedrail and was able to pull the assistive device away from the bed. The device appeared to be placed in between the mattress and box spring unattached. The surveyor observed ULP-B administer R10's morning medication. R5 and R10's records lacked the following: - a comprehensive assessment of the use of an assisted device (bedrail), - installation and use of the device according to manufacturer's guidelines, - evidence of physical inspection of the bedrail and mattress for areas of entrapment, stability, and correct installation of the device, and - evidence the licensee referred to the Consumer Product Safety Commission (CSPC) for bedrail recall information. R5's record also lacked evidence of an individualized risk and benefit discussion with the resident or the resident's representative. The records for both R5 and R10 lacked	02310		

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02310	Continued From page 126 information related to interventions implemented by the licensee to mitigate the resident's risk for safety pertaining to the use of the bedrail. On November 22, 2022, at 9:38 a.m., RN-C stated she did not know if R5 or R10 had a bedrail assessment. "Outside of that one admission I did, I can't help you. I can't help you with anything up there. I wish I could" The FDA "A Guide to Bed Safety" revised April 2010, 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". The United States Consumer Product Safety Commission (USCPSC) dated April 29, 2021, identified a recall involving adult portable bedrails that do not have safety retention straps to secure the bedrail to the bed frame to keep the bedrail from shifting out of place and creating a dangerous gap. This poses a serious risk for strangulation, entrapment, and death. The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) 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	02310		

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	24431	A. BUILDING: _____ B. WING _____	11/23/2022

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02310	Continued From page 127 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 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. No further information provided. TIME PERIOD OF CORRECTION: IMMEDIATE As of the time of exit on November 23, 2022, immediacy was not removed.	02310		

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03090	Continued From page 128	03090		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors Subd. 8.Notice to visitors. (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure a required notice was posted at the main entry way of the facility to display statutory language to disclose electronic monitoring activity. This had the potential to affect all current residents, staff, and visitors to the facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On November 21, 2022, at 9:34 a.m., upon entry to the facility, at the main entrance, the surveyor observed a sign that stated, "this area under 24 hour live and record video surveillance". The surveyor observed no other signs for electronic	03090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24431	A. BUILDING: _____ B. WING _____	11/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCANDIA CAPITAL PARTNERS LLC	101 NORTH 58TH AVENUE WEST DULUTH, MN 55807

(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
03090	Continued From page 129 monitoring at the facility. On November 21, 2022, at approximately 10:00 a.m., the surveyor observed four screens in the locked nurse's station. Three of the four screens appeared to be pointed at entrances to the building. Unlicensed personnel (ULP)-B stated she was not aware of any cameras in use inside the building. The surveyor and ULP-B did not observe any camera's inside of the facility. On November 21, 2022, at approximately 2:00 p.m., community coordinator (CC)-A stated the old owner had cameras. CC-A stated the facility did not have the required electronic monitoring signage. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090		

Minnesota Department of Health
Minnesota Department of Health
PO Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *11/21/22*
Time: 10:30:00
Report: 8010221221

Food and Beverage Establishment Inspection Report

Location:
Scandia Capital Partners LLC
101 North 58th Avenue West
Duluth, MN55807
St. Louis County, 69

Establishment Info:
ID #: 0021867
Risk: Low
Announced Inspection: No

License Categories:

Expires on: / /

Operator:
Scandia Capital Partners LLC

Phone #: 2186282705
ID #: 27352

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.

4-300 Equipment Numbers and Capacities

4-302.12B ** Priority 2 **

MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.

THERE WAS NOT A THIN SMALL DIAMETER PROBE FOOD THERMOMETER ON SITE.

Comply By: 12/01/22

4-300 Equipment Numbers and Capacities

4-302.13B ** Priority 2 **

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

THERE WERE NOT TEMPERATURE TEMP TAPES OR A WATERPROOF DISHWASHER THERMOMETER TO MEASURE THE SURFACE TEMPERATURE OF THE HOT WATER SANITIZING CYCLE OF THE DISHWASHER. PROVIDE EITHER TEMP TAPES OR A THERMOMETER.

Comply By: 12/01/22

2-100 Supervision

2-102.12AMN

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

THERE IS NOT A CERTIFIED FOOD PROTECTION MANAGER. ENROLL AN EMPLOYEE IN AN APPROVED FOOD SAFETY CLASS.

Comply By: 12/01/22

4-500 Equipment Maintenance and Operation

4-501.16B

MN Rule 4626.0760B Clean and sanitize the warewashing sink before and after washing produce, thawing food, or washing wiping cloths.

ONE COMPARTMENT OF THE TWO COMPARTMENT SINK IS TO BE CLEANED AND SANITIZED BEFORE WASHING PRODUCE.

Comply By: 11/22/22

Surface and Equipment Sanitizers

Chlorine: = 100 PPM at Degrees Fahrenheit
Location: SPRAY BOTTLE
Violation Issued: No

Hot Water: = at Degrees Fahrenheit
Location: DISHWASHER SANITIZING CYCLE-TEMP TAPE TURNED BLACK
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Upright Cooler
Temperature: 40 Degrees Fahrenheit - Location: RAW CHICKEN LEGS-GE
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 41 Degrees Fahrenheit - Location: MILK-GE
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 38 Degrees Fahrenheit - Location: SLICED HAM-GE
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 40 Degrees Fahrenheit - Location: MILK-AMANA
Violation Issued: No

Process/Item: Upright Freezer
Temperature: Degrees Fahrenheit - Location: FOODS FROZEN-BOTTOM OF GE
Violation Issued: No

Process/Item: Upright Freezer
Temperature: Degrees Fahrenheit - Location: FOODS FROZEN-FRIGIDAIRE
Violation Issued: No

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

COMMENTS:

DISCUSSED THE EXCLUSION OF EMPLOYEES ILL WITH VOMITING OR DIARRHEA FROM THE FOOD ESTABLISHMENT FOR 24 HOURS AFTER SYMPTOMS ARE GONE WITH KATHY.

DISCUSSED THE USE OF RAW EGGS THAT ARE ONLY TO BE USED IN ONE RESIDENT'S

SERVING AT A SINGLE MEAL IF THE EGGS ARE COMBINED, COOKED AND SERVED IMMEDIATELY OR IN BAKED GOODS THAT ARE THOROUGHLY COOKED IF EGGS ARE COMBINED AS AN INGREDIENT IMMEDIATELY BEFORE BAKING.

DISCUSSED THAT PASTEURIZED EGGS OR EGG PRODUCTS MUST BE SUBSTITUTED FOR RAW EGGS WHEN MORE THAN ONE EGG IS BROKEN, COMBINED AND NOT COOKED, BAKED, OR USED IMMEDIATELY.

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 8010221221 of 11/21/22.

Certified Food Protection Manager: See Report

Certification Number: _____ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed: _____
Kathy Mirtica

Signed: _____
8010

651-201-4500
health.foodlodging@state.mn.us

Report #: 8010221221

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Minnesota Department of Health
PO Box 64975
St. Paul, MN 55164-0975

No. of RF/PHI Categories Out	1	Date	11/21/22
No. of Repeat RF/PHI Categories Out	0	Time In	10:30:00
Legal Authority MN Rules Chapter 4626		Time Out	

	Address	City/State	Zip Code	Telephone
Scandia Capital Partners LLC	101 North 58th Avenue West	Duluth, MN	55807	2186282705

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
0021867	Scandia Capital Partners LLC	Full		L

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
Supervision							
1	(IN)	OUT			PIC knowledgeable; duties & oversight		
2	IN	(OUT)	N/A		Certified food protection manager, duties		
Employee Health							
3	(IN)	OUT			Mgmt/Staff;knowledge,responsibilities&reporting		
4	(IN)	OUT			Proper use of reporting, restriction & exclusion		
5	(IN)	OUT			Procedures for responding to vomiting & diarrheal events		
Good Hygenic Practices							
6	(IN)	OUT		N/O	Proper eating, tasting, drinking, or tobacco use		
7	(IN)	OUT		N/O	No discharge from eyes, nose, & mouth		
Preventing Contamination by Hands							
8	(IN)	OUT		N/O	Hands clean & properly washed		
9	IN	OUT	N/A	(N/O)	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10	(IN)	OUT			Adequate handwashing sinks supplied/accessible		
Approved Source							
11	(IN)	OUT			Food obtained from approved source		
12	(IN)	OUT	N/A	N/O	Food received at proper temperature		
13	(IN)	OUT			Food in good condition, safe, & unadulterated		
14	IN	OUT	N/A	(N/O)	Required records available; shellstock tags, parasite destruction		
Protection from Contamination							
15	(IN)	OUT	N/A	N/O	Food separated and protected		
16	(IN)	OUT	N/A		Food contact surfaces: cleaned & sanitized		
17	(IN)	OUT			Proper disposition of returned, previously served, reconditioned, & unsafe food		

	Compliance Status					COS	R
Time/Temperature Control for Safety							
18	IN	OUT	N/A	(N/O)	Proper cooking time & temperature		
19	IN	OUT	(N/A)	N/O	Proper reheating procedures for hot holding		
20	IN	OUT	(N/A)	N/O	Proper cooling time & temperature		
21	(IN)	OUT	N/A	N/O	Proper hot holding temperatures		
22	(IN)	OUT	N/A		Proper cold holding temperatures		
23	(IN)	OUT	N/A	N/O	Proper date marking & disposition		
24	IN	OUT	(N/A)	N/O	Time 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)	OUT	N/A		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)	OUT			Toxic 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

			COS	R
Safe Food and Water				
30	IN OUT (N/A)	Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32	IN OUT (N/A)	Variance obtained for specialized processing methods		
Food Temperature Control				
33		Proper cooling methods used; adequate equipment for temperature control		
34	IN OUT N/A (N/O)	Plant food properly cooked for hot holding		
35	IN OUT N/A (N/O)	Approved thawing methods used		
36	X	Thermometers provided & accurate		
Food Identification				
37		Food properly labled; original container		
Prevention of Food Contamination				
38		Insects, rodents, & animals not present		
39		Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
Proper Use of Utensils				
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
Utensil Equipment and Vending				
47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48	X	Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
Physical Facilities				
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 11/22/22

Inspector (Signature)