DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

March 14, 2022

Administrator
Restart, Inc.
614 8th Street Southeast
Minneapolis, MN 55414

RE: Project Number(s) SL25373015

Dear Administrator:

On March 4, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the December 15, 2021, evaluation were corrected. The follow-up evaluation verified that the facility is in substantial compliance.

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. You are encouraged to retain this document for your records.

Please feel free to call me with any questions.

Sincerely,

Jessica Gallmeier, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-247-0268 Fax: 651-215-9697

PMB

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

ATTENTION
LETTER AMENDED FOR TAG 0510 TO ADD PENALTY

Electronically Delivered

March 11, 2022

Administrator
Restart, Inc.
614 8th Street Southeast
Minneapolis, MN 55414

RE: Project Number(s) SL25373015

Dear Administrator:

After further review by Department staff, it was discovered that our January 18, 2022 letter was missing the $500.00 penalty for tag 0510 - 144G.41 SUBD. 3 - Infection Control Program, from the December 15, 2021 evaluation. This amended letter contains information regarding the appeal process. There are no other changes to the January 18, 2022 letter. The State Form remains the same.

The Minnesota Department of Health completed an evaluation on December 15, 2021, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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 - 0510 - 144g.41 Subd. 3 - Infection Control Program = $500.00

The total amount you are assessed is $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:

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

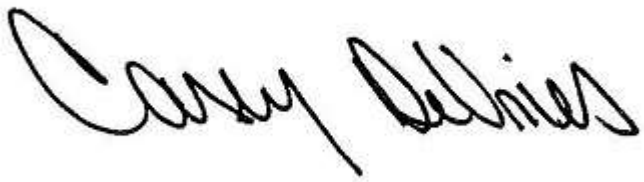
REQUESTING A HEARING

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.

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

Sincerely,



Casey DeVries, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-5917 Fax: 651-215-9697

PMB

Electronically Delivered

January 18, 2022

Administrator
Restart, Inc.
614 8th Street Southeast
Minneapolis, MN 55414

RE: Project Number(s) SL25373015-0

Dear Administrator:

The Minnesota Department of Health completed an evaluation on December 15, 2021, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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.
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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, no immediate fines are assessed.

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 surveys. 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 general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general reconsideration requests to:
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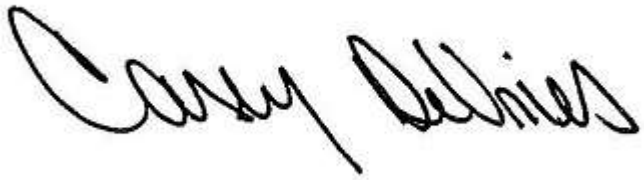
St. Paul, MN 55164-0970 St. Paul, MN 55164-0970

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

Sincerely,



Casey DeBries, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-5917 Fax: 651-215-9697

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25373	A. BUILDING: _____ B. WING _____	12/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RESTART INC	614 8TH STREET SE MINNEAPOLIS, MN 55414

(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 Initial comments *****ATTENTION****** ASSISTED LIVING LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey investigation. 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#25373015 On December 13, 2021, through December 15, 2021, 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 seven (7) residents receiving services under the provider's Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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 SUBDIVISION 1-3.	
0 430 SS=C	144G.40 Subd. 2 Uniform checklist disclosure of services	0 430		

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RESTART INC	614 8TH STREET SE MINNEAPOLIS, MN 55414

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0 430	Continued From page 1 (a) All assisted living facilities must provide to prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a). This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide a copy of the uniform checklist disclosure of services (UDALSA) with the required content for one of one resident (R1) with records reviewed. 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:	0 430		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RESTART INC	614 8TH STREET SE MINNEAPOLIS, MN 55414

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0 430	Continued From page 2 R1's record lacked a uniform checklist disclosure of services (UDALSA) to include: - a disclosure of the categories of assisted living licenses available and the category of license held by the facility; - a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and - an oral explanation of all services offered under the contract. R1's Service Plan, dated January 31, 2021, indicated services included medication administration, daily prompts with hygiene/grooming, assistance with laundry, housekeeping and food preparation. On December 14, 2021, at approximately 8:35 a.m., the surveyor observed unlicensed personnel (ULP)-C administer oral medications to R1. On December 14, 2021, at 9:40 a.m., licensed assisted living director (LALD)-B stated the licensee had not given or explained the UDALSA to R1 or his representative nor to any of the six other residents receiving assisted living services from the licensee. The licensee lacked a policy regarding the uniform checklist disclosure of services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 430		

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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 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	0 480		

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0 480	Continued From page 4 and Beverage Establishment Inspection Report dated December 13, 2021, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 500 SS=F	144G.41 Subd. 2 Policies and procedures Each assisted living facility must have policies and procedures in place to address the following and keep them current: (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, 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) orientation to and implementation of the assisted living bill of rights; (8) infection control practices; (9) reminders for medications, treatments, or exercises, if provided; (10) conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with	0 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 500	Continued From page 5 current United States Centers for Disease Control and Prevention standards; (11) ensuring that nurses and licensed health professionals have current and valid licenses to practice; (12) medication and treatment management; (13) delegation of tasks by registered nurses or licensed health professionals; (14) supervision of registered nurses and licensed health professionals; and (15) supervision of unlicensed personnel performing delegated tasks. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they had met the requirements of licensure, by attesting the managerial officials who were in charge of the day-to-day operations, had developed and implemented current policies and procedures, as required, with records 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 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 entrance conference on December 13, 2021, at approximately 11:40 a.m., licensed assisted living director (LALD)-B stated she reviewed the current assisted living regulations online.	0 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 500	Continued From page 6 The licensee failed to ensure the following policies and procedures were in place and kept current: - orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; - orientation to and implementation of the assisted living bill of rights; - ensuring that nurses and licensed health professionals have current and valid licenses to practice; - supervision of registered nurses and licensed health professionals; and - supervision of unlicensed personnel performing delegated tasks. On December 15, 2021, at approximately 11:19 a.m., LALD-B verified the licensee did not have the policies listed above. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 500		
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.	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 510	Continued From page 7 (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program to comply with accepted health care, medical, and nursing standards for infection control and current recommendations for COVID-19. This deficient practice had the potential to affect the licensee's seven current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: PERSONAL PROTECTIVE EQUIPMENT (PPE) On December 13, 2021, at approximately 11:00 a.m., upon entering the facility, the surveyor observed licensed assisted living director (LALD)-B, unlicensed personnel (ULP)-C, and registered nurse (RN)-A wearing medical-grade facemasks, but no eye protection. On December 14, 2021, at approximately 8:08 a.m., the surveyor observed ULP-C administer medications to R3 and R1, wearing a medical-grade facemask, but no eye protection. On December 14, 2021, at approximately 8:30	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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RESTART INC	614 8TH STREET SE MINNEAPOLIS, MN 55414

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0 510	Continued From page 8 a.m., the surveyor observed an unidentified male who was orientating as an unlicensed personnel, wear a medical-grade facemask below his nose, and without eye protection. On December 14, 2021, at approximately 9:10 a.m., facility manager (FM)-F stated staff wore eye protection during a recent COVID outbreak when providing cares, but stated she didn't think they needed to wear them now. On December 14, 2021, at approximately 9:15 a.m., LALD-B verified staff were not wearing eye protection, and stated she was unaware that they needed to. LALD-B stated the licensee had "A whole case" of face shields and she would direct staff to wear them. Minnesota Department of Health (MDH) COVID-19 Personal Protective Equipment (PPE) Grid for Congregate Care Settings dated June 30, 2021, indicated health care workers (HCW's) with face-to-face contact with residents should wear a medical grade well-fitting facemask and eye protection. MDH Responding to and Monitoring COVID-19 Exposures in Health Care Settings dated December 8, 2021, indicated to institute universal masking of all health care workers for source control. Universal masking is intended to protect both patients and employees from infected health care workers who may shed virus into the environment before onset of symptoms. Additionally, the guidance indicated to institute use of eye protection (e.g., face shield, goggles) as a way to reduce COVID-19 exposure risk. Eye protection is recommended, at a minimum, for all routine outpatient, acute care, and long-term care encounters when PPE supplies allow. Use of all	0 510		

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	25373	A. BUILDING: _____ B. WING _____	12/15/2021

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0 510	Continued From page 9 appropriate PPE can reduce the number of exposures for which exclusion from work is recommended. The licensee's Standard (Universal) Precautions for Infection policy dated August 1, 2021, directed staff to wear masks, eye protection, or face shields when providing care that is likely to generate splashes of blood, body fluids, or feces. The licensee's COVID-19 Preparedness for Residential Services, Restart Inc., updated December 2, 2020, included, "All staff, during their entire shift will wear a surgical face mask and protective shield or protective goggles." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and 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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0 550	Continued From page 10 Based on observation, interview, and record review, the licensee failed to post required information related to the licensee's grievance procedure with the required content. This had the potential to affect the licensee's seven (7) current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 entrance to the facility on December 13, 2021, at approximately 11:00 a.m., the surveyor observed a two-page Grievance Policy dated September 13, 2019, posted on the bulletin board near the front entrance. The policy included contact information for the individual responsible for handling resident grievances; however, lacked the contact information for the state and applicable Office of Ombudsman for Long Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center, as required. On December 13, 2021, at approximately 2:15 p.m., licensed assisted living director (LALD)-B confirmed the required content noted above was not posted. No further information was provided.	0 550		

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0 550	Continued From page 11 TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	0 550		
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: Based on observation and interview, the licensee failed to support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment as required. This had the potential to affect all of the licensee's current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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	0 640		

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0 640	Continued From page 12 a large portion or all of the residents). The findings include: The licensee failed to: - post the 911 emergency number in common areas and near telephones provided by the assisted living facility. During entrance to the facility on December 13, 2021, at approximately 11:00 a.m., the surveyor observed the entry area, common areas, and medication rooms/charting areas within the facility, and noted there was no posting of the 911 emergency number, as required. On December 13, 2021, at approximately 2:15 p.m., licensed assisted living director (LALD)-B confirmed the required content noted above was not posted. The licensee lacked a policy regarding the required posting. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	0 640		
0 650 SS=E	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this	0 650		

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0 650	Continued From page 13 chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records contained the required content for three of four employees (registered nurse (RN)-A, licensed practical nurse (LPN)-E and unlicensed personnel (ULP)-D) with records 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 a pattern scope (when more than a limited number of residents are affected, more	0 650		

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0 650	Continued From page 14 than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: RN-A RN-A started employment on September 17, 2003 and began providing assisted living services on August 1, 2021. RN-A's employee record lacked the following: - current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; and - documentation of annual performance reviews that identify areas of improvement needed and training needs. LPN-E LPN-E started employment on June 1, 2008, and began providing assisted living services on August 1, 2021. LPN-E's record lacked evidence of the following: - current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; and - documentation of annual performance reviews that identify areas of improvement needed and training needs. ULP-D ULP-D had a start date and began providing assisted living services on October 14, 2021. ULP-D's employee record lacked the following: - current job description, including qualifications, responsibilities, and identification of staff persons providing supervision.	0 650		

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0 650	Continued From page 15 On December 14, 2021, at approximately 2:36 p.m., licensed assisted living director (LALD)-B verified the above contents were missing from the employee's records. The licensee lacked a policy regarding required contents for the employee record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing 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	0 680		

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0 680	Continued From page 16 allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have a written emergency preparedness plan with all of the required content. In addition, the licensee failed to have a written policy and procedure regarding missing residents. This had the potential to affect all seven (7) current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: Upon entrance to the facility on December 13, 2021, at approximately 11:00 a.m., the surveyor observed a multiple page document posted in the common area titled "Restart--614 Emergency Preparedness Guide" dated January 2009. The licensee's plan lacked a hazard vulnerability assessment in addition to the following required content: - a comprehensive program to include infectious diseases and pandemics; - a description of the population served by the licensee;	0 680		

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0 680	Continued From page 17 - process for emergency preparedness (EP) collaboration with state and local EP officials/organizations; - procedure for tracking staff and residents; and - subsistence needs for staff and residents during emergency situations. - development of policies/procedures to address: - evacuation plan; - shelter in place; - the medical record documentation system to preserve resident information; - use of volunteers; - emergency staff strategies; and - the facility's role in providing care and treatment at alternative sites. - a communication plan that included: - arrangement with other facilities; - names and contact information for resident physicians; - contact information for federal, state, tribal, local EP staff, or the ombudsman; - primary and alternative means for communicating with facility staff, or 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 emergency plan with residents and their families. - EP training and testing program; - EP training program for staff (including documentation of training provided); and - EP testing/annual testing requirements. On December 14, 2021, at approximately 12:32 p.m., licensed assisted living director (LALD)-B	0 680		

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0 680	Continued From page 18 stated the information provided regarding the emergency preparedness plan was everything the licensee had available and verified the plan had missing and outdated information. LALD-B also verified the licensee lacked a written policy regarding missing residents. The licensee's Emergency Response, Reporting, & Review Policy dated February 6, 2020, noted an emergency response plan must be readily available to staff and persons receiving services, and must include procedures for emergency evacuation and emergency sheltering, including how to report a fire or other emergency, procedures to notify, relocate, and evacuate occupants, floor plan, site plan, responsibilities each staff person must assume in case of an emergency, procedures for conducting quarterly drills, procedures for relocation when services are interrupted, and emergency escape plan for each person. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
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: (1) housing; (2) assisted living services, whether provided directly by the facility or by management	0 900		

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0 900	Continued From page 19 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 contract prior to providing assisted living services for one of one resident (R1) with records reviewed. In addition, the licensee failed to provide a complete unsigned copy of the contract to the Office of Ombudsman for Long-Term Care. 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	0 900		

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0 900	Continued From page 20 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 was admitted under the licensee's former comprehensive license on October 16, 2019 and began receiving services under the licensee's assisted living license on August 2, 2021. R1's Service Plan dated January 31, 2021, indicated services included medication administration, daily prompts with hygiene/grooming, assistance with laundry, housekeeping and food preparation. On December 14, 2021, at approximately 8:35 a.m., the surveyor observed unlicensed personnel (ULP)-C administer oral medications to R1. R1's record lacked a written contract that contained all the terms concerning the provision of: - housing; - assisted living services, whether provided directly by the facility or by management agreement or other agreement; and - the resident's service plan, if applicable. On December 14, 2021, at approximately 9:40 a.m., licensed assisted living director (LALD)-B provided a blank contract to the surveyor and stated the licensee had not given the contract to R1 or to any of the licensee's residents, therefore, there were no signed contracts. LALD-B stated,	0 900		

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0 900	Continued From page 21 "We work off of the service plan." In addition, LALD-B stated the licensee had not provided a complete unsigned copy of the contract to the Office of Ombudsman for Long-Term Care as required. The licensee lacked a policy regarding executing a written contract with the residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 900		
01560 SS=C	144G.64 (a, b, c) TRAINING IN DEMENTIA CARE REQUIRED (5) new employees may satisfy the initial training requirements by producing written proof of previously completed required training within the past 18 months. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and other dementias; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; (4) communication skills; and (5) person-centered planning and service delivery. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide in written or electronic	01560		

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01560	Continued From page 22 form to residents, families, or other persons who requested it, a description of the dementia care training program, the categories of employees trained, the frequency of training and the basic topics covered. 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: During the entrance conference on December 13, 2021, at approximately 11:40 a.m., licensed assisted living director (LALD)-B stated the licensee provided services to residents with traumatic brain injuries, which had the potential for increased risk of dementia and other related disorders. LALD-B stated the licensee lacked a written description of the licensee's dementia care training program, the categories of employees trained, the frequency of training, and the basic topics covered. The licensee lacked a policy regarding the provision of a written or electronic description of the licensee's dementia care training program. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01560		

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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
01610	Continued From page 23	01610		
01610 SS=F	144G.70 Subd. 2 Initial reviews, assessments, and monitoring (a) Residents who are not receiving any services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan 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. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. 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 a nursing assessment of the physical and cognitive needs of the resident for one of one resident (R1) as required with records 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 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).	01610		

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	25373	A. BUILDING: _____ B. WING _____	12/15/2021

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01610	Continued From page 24 The findings include: During the entrance conference on December 13, 2021, at approximately 12:20 p.m., registered nurse (RN)-A stated she completed an RN supervision every 90 days and when the resident presented with a change in condition, and stated, "I can tell you right now, it doesn't include all of those [required] pieces." R1 was admitted under the licensee's former comprehensive license on October 16, 2019 and began receiving services under the licensee's assisted living license on August 2, 2021. R1's Service Plan dated January 31, 2021, indicated R1's services included medication administration, daily prompts with hygiene/grooming, assistance with laundry, housekeeping and food preparation. On December 14, 2021, at approximately 8:35 a.m., the surveyor observed unlicensed personnel (ULP)-C administer oral medications to R1. R1's record included a Person Served Monitoring and Reassessment-RN Supervision dated October 4, 2021 and identified a 90-day visit. The assessment indicated R1 required assistance with daily oxygen saturation, monthly vitals for blood pressure checks and daily temperature checks. The assessment noted the nurse's observation of R1's continence, cleanliness, appropriate dress, maintenance of a clean and safe environment, R1's satisfaction with services, and no changes were made to the care plan. The assessment identified the nurse set up R1's medications, which were administered by trained	01610		

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01610	Continued From page 25 staff, and medication administration was observed, with no additional training provided. The assessment did not include all of the elements of the uniform assessment tool as required. On December 14, 2021, at approximately 9:40 a.m., licensed assisted living director (LALD)-B confirmed the licensee's assessment tool did not include all of the required content of the uniform assessment tool and verified the same assessment was used for all residents. The licensee's policy Restart Inc. Assessment Schedules, dated August 1, 2021, indicated the ongoing client monitoring and reassessment was to be completed every 90 days, by the RN or licensed practical nurse (LPN) and may be conducted at the resident's residence or through the use of telecommunication methods; however, lacked direction as to the required content of the assessment. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01610		
01650 SS=F	144G.70 Subd. 4 Service plan, implementation, and revisions t (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 26 assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan included the required content for one of one resident (R1) with records 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 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:	01650		

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01650	Continued From page 27 R1's service plans lacked the following required content: - the methods of monitoring staff providing services. R1's Service Plan, dated January 31, 2021, indicated R1's services included medication administration, daily prompts with hygiene/grooming, assistance with laundry, housekeeping and food preparation. The service plan indicated staff would be supervised within the first 30 days of service delivery and periodically thereafter; however, the service plan lacked the above required content. On December 14, 2021, at approximately 8:35 a.m., the surveyor observed unlicensed personnel (ULP)-C administer oral medications to R1. On December 14, 2021, at 9:40 a.m., licensed assisted living director (LALD)-A verified the above content was missing from R1's service plan, and confirmed the same template was utilized for all residents. The licensee lacked a policy regarding the required contents of the service plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01650		
01770 SS=F	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be	01770		

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01770	Continued From page 28 administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure documentation of medication setup included all the required content for one of one resident (R1) with records 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), 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 December 13, 2021, at approximately 12:25 p.m., registered nurse (RN)-A confirmed the licensee provided medication management services to five (5) of the current seven (7) residents, which included medication setup by the RN into medication planner boxes (a plastic medication box with designated compartments for days and times), for later administration by unlicensed personnel (ULP). In addition, RN-A stated she assisted the remaining two (2) of the current seven (7) residents to set up their own medications into medication pill boxes, as part of their programming. R1's record lacked documentation by the licensed nurse at the time of medication setup to include	01770		

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01770	Continued From page 29 the date of medication setup, the name of the medication, quantity of dose, times to be administered, route of administration, and name of the person completing medication setup. R1's diagnoses included traumatic brain injury, seizure disorder, and Asperger's Syndrome. R1's service plan, dated January 31, 2021, and Medication Plan, dated February 3, 2021, indicated R1 received medication management services to include medication setup in medication planner according to the scheduled medication administration times (a.m. or p.m.) by licensee's nurse and medication administration by trained unlicensed personnel (ULP). R1's prescriber orders dated November 30, 2021, included four medications to control and prevent seizures and one dietary supplement. On December 14, 2021, at approximately 8:35 a.m., the surveyor observed ULP-C administer oral medications to R1 from a medication planner. On December 14, 2021, at approximately 12:11 p.m., RN-A stated she did not document medication setup to include date of medication setup, the name of the medication, quantity of dose, times to be administered, route of administration, or name of the person completing medication setup. The licensee's Safe Medication Assistance and Administration Policy dated August 31, 2020, indicated staff must document the following in the resident's MAR (medication administration record): 1. Dates of set-up;	01770		

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01770	Continued From page 30 2. Name of the medication; 3. Quantity of dose; 4. Times to be administered; and 5. Route of administration at time of set-up. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770		
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	01790		

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01790	Continued From page 31 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 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 the registered nurse (RN) developed comprehensive written procedures for the unlicensed personnel (ULP) providing medications for residents having unplanned time away when the licensed nurse	01790		

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01790	Continued From page 32 was not available with records 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 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 December 13, 2021, at approximately 12:20 p.m., registered nurse (RN)-A confirmed the licensee provided medication management services to the residents. The licensee's written procedure titled Procedure: Leave of Absence (LOA) Medication, dated August 2018, lacked the following: - a review by the RN of the completion of the task to verify that the task was completed accurately by the unlicensed personnel; and - 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. On December 15, 2021, at approximately 10:25 a.m., RN-A confirmed the written procedures lacked the above required content. The licensee lacked a policy regarding LOA medications. No further information was provided.	01790		

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01790	Continued From page 33 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, interview, and record review, the licensee failed to ensure prescription medications were securely locked in a substantially constructed compartment and permitted only authorized personnel to have access. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on December 13, 2021, at approximately 12:25 p.m., registered nurse (RN)-A confirmed the licensee provided medication management services to all of the licensee's current residents, which included medication setup by the RN into medication	01880		

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01880	Continued From page 34	01880		

planner boxes (a plastic medication box with designated compartments for days and times), for later administration by unlicensed personnel (ULP) for five (5) of the seven (7) residents, and those medications were securely stored in a locked medication storage room located in the office area. In addition, RN-A stated she assisted two (2) residents to set up their own medications into medication pill boxes, one of which was stored in the storage room, and the other, for resident (R2), was stored in R2's apartment.

R2's diagnoses included cerebrovascular accident (stroke), cognitive impairment due to vascular dementia and seizure disorder.

R2's service plan, dated May 28, year not documented, indicated R2 received medication reminders and administration, and included, "If the security of medications is compromised Restart Inc. will provide an appropriate alternative secure area for medications."

R2's physician orders, dated September 22, 2021, included one blood thinner, one medication to help lower bad cholesterol, one antihypertensive, one medication used to treat heart failure, and one dietary supplement.

On December 14, 2021, at approximately 12:24 p.m., RN-A stated R2 kept his medications in a locked box, in his top dresser drawer. The surveyor observed R2's room with RN-A. R2 was in his room and opened his top dresser drawer to display the unsecured medication planner box in the dresser drawer. When RN-A asked where the locked box was, R2 pulled it out from under his bed. RN-A stated R2's room was, "Usually locked," but stated it was hard to guarantee the door was always locked when R2 wasn't in his

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01880	Continued From page 35 room. RN-A stated the medications needed to be secured, and verified the locked box was not a substantially constructed compartment to keep medications secure. The licensee's Procedure: Medication storage and Security, dated August 23, 2018, indicated medications must be locked at all times, and all residents on self-medication program would have locked security boxes in their bedroom. Also included, the site nurse would periodically check for storage compliance and make changes as needed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01920 SS=F	144G.71 Subd. 23 Loss or spillage (a) Assisted living facilities providing medication management must develop and implement procedures for loss or spillage of all controlled substances defined in Minnesota Rules, part 6800.4220. These procedures must require that when a spillage of a controlled substance occurs, a notation must be made in the resident's record explaining the spillage and the actions taken. The notation must be signed by the person responsible for the spillage and include verification that any contaminated substance was disposed of according to state or federal regulations. (b) The procedures must require that the facility providing medication management investigate any known loss or unaccounted for prescription drugs and take appropriate action required under state or federal regulations and document the	01920		

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01920	Continued From page 36 investigation in required records. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop and implement procedures for loss and spillage of all controlled substances defined in Minnesota Rules part 6800.4220. 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 December 13, 2021, at approximately 12:20 p.m., registered nurse (RN)-A confirmed the licensee provided medication management services to residents, including storage of controlled substances. On December 14, 2021, at approximately 12:11 p.m., the surveyor observed the licensee's secure storage of controlled substances with RN-A. On December 15, 2021, at approximately 10:43 a.m., RN-A stated the licensee did not have a procedure for loss or spillage of controlled substances as required. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01920		

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02240 SS=C	144G.90 Subdivision 1 Assisted living bill of rights; notification (a) An assisted living facility must provide the resident a written notice of the rights under section 144G.91 before the initiation of services to that resident. The facility shall make all reasonable efforts to provide notice of the rights to the resident in a language the resident can understand. (b) In addition to the text of the assisted living bill of rights in section 144G.91, the notice shall also contain the following statement describing how to file a complaint or report suspected abuse: "If you want to report suspected abuse, neglect, or financial exploitation, you may contact the Minnesota Adult Abuse Reporting Center (MAARC). If you have a complaint about the facility or person providing your services, you may contact the Office of Health Facility Complaints, Minnesota Department of Health. You may also contact the Office of Ombudsman for Long-Term Care or the Office of Ombudsman for Mental Health and Developmental Disabilities." (c) The statement must include contact information for the Minnesota Adult Abuse Reporting Center and the telephone number, website address, e-mail address, mailing address, and street address of the Office of Health Facility Complaints at the Minnesota Department of Health, the Office of Ombudsman for Long-Term Care, and the Office of Ombudsman for Mental Health and Developmental Disabilities. The statement must include the facility's name, address, e-mail, telephone number, and name or title of the person at the facility to whom problems or complaints may be directed. It must also include a statement that the facility will not retaliate because of a complaint.	02240		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25373	A. BUILDING: _____ B. WING _____	12/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RESTART INC	614 8TH STREET SE MINNEAPOLIS, MN 55414

(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
02240	Continued From page 38 (d) A facility must obtain written acknowledgment from the resident of the resident's receipt of the assisted living bill of rights or shall document why an acknowledgment cannot be obtained. Acknowledgment of receipt shall be retained in the resident's record. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a written acknowledgement of receipt of the current assisted living bill of rights was obtained for one of one resident (R1) with records reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 was admitted under the licensee's former comprehensive license for services on October 16, 2019 and began receiving services under the licensee's assisted living license on August 1, 2021. R1's Service Plan dated January 31, 2021, indicated services included medication administration, daily prompts with hygiene/grooming, assistance with laundry, housekeeping and food preparation. On December 14, 2021, at approximately 8:35 a.m., the surveyor observed unlicensed	02240		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25373	A. BUILDING: _____ B. WING _____	12/15/2021

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RESTART INC	614 8TH STREET SE MINNEAPOLIS, MN 55414

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02240	Continued From page 39 personnel (ULP)-C administer oral medications to R1. R1's record lacked written acknowledgement that he received the current Minnesota Bill of Rights for Assisted Living Residents dated May 16, 2021 as required. On December 14, 2021, at approximately 9:40 a.m., licensed assisted living director (LALD)-B verified none of the licensee's seven residents or the residents' representatives had received a written copy of the Assisted Living Bill of Rights, therefore, the licensee lacked written acknowledgement of the receipt. The licensee lacked a policy regarding providing the Assisted Living Bill of Rights to residents or the resident's representatives including obtaining a written acknowledgement of the receipt. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02240		
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.	03090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25373	A. BUILDING: _____ B. WING _____	12/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RESTART INC	614 8TH STREET SE MINNEAPOLIS, MN 55414

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03090	Continued From page 40 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the required notice was posted at the main entry way of the facility to display statutory language to disclose electronic monitoring activity, potentially affecting all current residents in the assisted living facility, staff, and any visitors of the licensee. This practice resulted in a level one violation (a violation that has not potential to cause more than a minimal impact on the client 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 clients). The finding include: On December 13, 2021, at approximately 11:00 a.m., upon arrival to the facility, the surveyor observed inside and outside the front entrance and inside the front entrance, which had no posting for electronic monitoring devices. On December 14, 2021, at approximately 8:08 a.m., licensed assisted living director (LALD)-B stated electronic monitoring was utilized in the back entrance of the facility; however, verified no posting was available related to the statutory language for electronic monitoring. The licensee lacked a policy regarding the requirement to post a sign to disclose electronic monitoring activity. No further information was provided.	03090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RESTART INC	**614 8TH STREET SE MINNEAPOLIS, MN 55414**

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03090	Continued From page 41 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	03090		

Minnesota Department of Health
Division of Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *12/13/21*
Time: 13:00:00
Report: 1025211338

Food and Beverage Establishment Inspection Report

Location:
Restart Inc
614 8th Street Se
Minneapolis, MN55414
Hennepin County, 27

Establishment Info:
ID #: 0038524
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6127013645
ID #:

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

The following orders were issued during this inspection.

3-500B Microbial Control: hot and cold holding

3-501.16A2 ***** Priority 1 *****

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

Downstairs refrigerator at 43 deg F. Maintain TCS foods at or below 41 deg F. Thermostat was adjusted during inspection; verify using the available food thermometer.

Corrected on Site

2-100 Supervision

2-102.12AMN

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

Employ a CFPM for the facility, and post the CFPM certificate (or copy) with the license.

Comply By: 03/13/22

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

3-305.11A

MN Rule 4626.0300A Store all food in a clean, dry location; where it is not exposed to splash, dust or other contamination; and at least 6 inches above the floor.

When existing shelving is replaced, provide shelving in the basement storage space with a bottom shelf at least 6 inches up off of the floor.

Comply By: 03/13/22

Food and Equipment Temperatures

Process/Item: Ambient
Temperature: 41 Degrees Fahrenheit - Location: Upstairs refrigerator dial
Violation Issued: No

Process/Item: Milk
Temperature: 41 Degrees Fahrenheit - Location: Upstairs refrigerator
Violation Issued: No

Process/Item: Ambient
Temperature: 43 Degrees Fahrenheit - Location: Downstairs refrigerator
Violation Issued: Yes

Process/Item: Milk
Temperature: 43 Degrees Fahrenheit - Location: Downstairs refrigerator
Violation Issued: Yes

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

GENERAL DISCUSSION
Reviewed staff training binder and materials. Fact sheets for final cook temperatures, digital food thermometer, available on-site.
Discussed monitoring cooler temperatures, dial thermometers available in each refrigerator
Facility food is separate from resident personal items (downstairs refrigerator)
Reviewed staff health and hygiene requirements; no staff, residents, volunteers, etc permitted to work with food or utensils if they are ill with vomiting and/or diarrheal illness
Chemicals stored separate from food; paper products stored over chemicals in mudroom cabinets
Food source Costco, Sam's Club. Email alerts on recalls received through email
Staff purchases items on location, able to screen for damaged packaging
Discussed cook temperature for frozen food and meals
Pest control contract and plan in place for facility
CFPM requirements for individual facilities
Microwave cooking (reported majority of cooking takes place on the stovetop, in oven)
Sink usage, 2 basin sinks. Discussed having a basin dedicated to handwashing. Soap, paper towels provided.
Dishwasher was in use during inspection. (On the inside, the label will tell whether the unit has the NSF Standard 184 for residential dishwashers. Test kit is available on site for 160 deg F water contact temperature).
Provide a bus tub or alternate container to use as a 3rd/sanitize compartment.
Quaternary ammonia used for sanitizing food contact surfaces, 1 tablet per 1 gallon. Test kit available.
No wood used as a food contact surface

Discussed same-day service of TCS foods (eg not saving leftovers provided by the facility). For reference, please see MN 4626.0506 part G. Location has residential style refrigerators, appliances, etc.

PHYSICAL FINISHES
Hollow base cabinets in the upstairs and downstairs kitchens. Provide cabinetry which has a sealed base, or is elevated on approved legs.

Basement shelving is plastic and the base shelf rests on the floor. When shelves are replaced, replace with a unit where the bottom shelf is up off of the floor by at least 6" for cleaning and pest control, or has casters/can be easily moved for cleaning and inspection.

Paint areas of cabinetry where wood is visible through the previous finish to seal and protect from water damage.

Reviewed with MDH L DeGagne, and staff Maria F, present for upstairs and downstairs inspection

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 1025211338 of 12/13/21.

Certified Food Protection Manager: Maria F

Certification Number: TBD Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed: _____
Establishment Representative

Signed: Casey Kipping

Casey Kipping
Public Health Sanitarian II
Freeman Building St Paul
651-201-4513
casey.kipping@state.mn.us