DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

April 19, 2023

Licensee
Chaska Heights Senior Living
3120 Chestnut Street North
Chaska, MN 55318

RE: Project Number(s) SL32539015

Dear Licensee:

On April 18, 2023, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the February 3, 2023 survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: Jess.Schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 651-281-9796

JMD

Electronically Delivered

March 3, 2023

Licensee
Chaska Heights Senior Living
3120 Chestnut Street North
Chaska, MN 55318

RE: Project Number(s) SL32539015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on February 3, 2023, 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.

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

The total amount you are assessed is $3,000.00. 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.

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,

Jess Schoenecker, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: Jess.Schoenecker@state.mn.us
Phone: 651-201-3789 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
	32539	A. BUILDING: _____ B. WING _____	02/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHASKA HEIGHTS SENIOR LIVING	3120 CHESTNUT STREET NORTH CHASKA, MN 55318

(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(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: SL32539015 On January 30 through February 2, 2023, 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 142 active residents; 75 receiving services under the Assisted Living Dementia Care license. On February 3, 2023, the immediacy of correction order 0470 has been removed, however non-compliance remains 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.	
0 470 SS=I	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that:	0 470		

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0 470	Continued From page 1 (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 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 develop and implement a staffing plan to meet the scheduled and reasonably foreseeable unscheduled needs of the residents. This had the 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	0 470		

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0 470	Continued From page 2 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 was admitted on November 11, 2020. R2's Service Addendum to the Assisted Living Contract with effective date of January 30, 2023, indicated under Evacuation Status, "Resident requires 2 staff for transfers due to use of mechanical lift." R2's untitled documented printed on January 30, 2023, indicated by licensed assisted living director (LALD)-C as R2'a task list indicated under Routine Services read, "Transfer Full Mechanical Lift Resident request to use a full body lift to get out of bed in the morning with the assist of 2. Resident will use sit to stand lift throughout the day for other cares and transfers" and "Toileting/Incontinence Assist Client will ask for assistance to commode/toilet for BM's. Sit-to-Stand per client request with assistance of 2." R2's NEW Nursing Assessment dated January 24, 2023, indicated under Individual Abuse Prevention Plan section 25.a.1 read, "A. Requires physical assist of 2 to exit building, d/t physical or cognitive impairments," and "D. Requires assist of 2 staff for transfer using mechanical lift." Additionally, the assessment indicated R2 required full cares (staff do all the physical work) for dressing and undressing along with transfers to commode or shower chairs for bowel and hygiene needs.	0 470		

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0 470	Continued From page 3 On January 31, 2023, at approximately 9:50 a.m., the surveyor observed unlicensed personnel (ULP)-E and ULP-F provide activities of daily living (ADL) services to R2 including dressing, personal hygiene, catheter cares, and transferring via a two-person mechanical lift to R2's electric wheelchair. R2 was unable to assist in any cares due to R2's physical limitation related to R2's diagnosis of multiple sclerosis, weakness, and muscle spasms. On January 30, 2023, at approximately 10:00 a.m. during the entrance conference, LALD-C indicated the licensee staffed two or three ULPs during the overnight hours. LALD-C indicated when two ULPs were present, one would work in the locked memory care unit, and one would work in the assisted living area. On January 30, 2023, at approximately 12:00 p.m., LALD-C provided an untitled document dated January 29 - February 4, 2023, and indicated the document was the licensee's weekly schedule. The schedule indicated on Sunday, January 29, 2023, one staff member worked the overnight shift from 11:00 p.m. to 7:00 a.m. On Monday, January 30, Thursday, February 2, and Friday, February 3, 2023, two staff members were scheduled to work the overnight shift. On January 30, 2023, at approximately 12:00 p.m., LALD-C provided an untitled document printed on January 30, 2023, with the licensee's address and, "Resident," in the upper right corner. LALD-C indicated the document contained the names of all residents at the facility and those who required assistance with transfers were indicated with a "1," for those residents who required a one-person transfer, and a "2," for	0 470		

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0 470	Continued From page 4 those residents who required a two-person transfer. The document indicated two residents required a two-person transfer who did not reside in the licensee's locked memory care unit. On January 30, 2023, at 1:40 p.m., LALD-C indicated the licensee had scheduled only two staff members on the above indicated overnight shifts. LALD-C indicated licensee should staff three employees on the overnight shift in order to meet the needs of residents who required a two-person transfer when the resident did not reside in a memory care unit. The licensee's Staffing Requirements policy dated August 2021, indicated the licensee would schedule staffing to, "timely meet the residents' schedule and reasonably foreseeable unscheduled needs." No further information provided. TIME PERIOD FOR CORRECTION: Immediate Immediacy is removed on February 3, 2023, by evaluation supervisor review, however noncompliance remains at a scope and level of I.	0 470		
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	0 580		

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0 580	Continued From page 5 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 implement and maintain a quality management program (QMP) appropriate to the size of the facility and relevant to the type of services provided. This had the potential to affect all 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: On January 30, 2023, at approximately 10:00 a.m., during the entrance conference, licensed assisted living director (LALD)-C stated the licensee was aware of the QMP requirement but one had not been developed or implemented. LALD-C stated the licensee provided ongoing improvement as areas were identified, but no meeting minutes, tracking, or specific improvement projects would be documented. The licensee's 1.26 Quality Assurance and Performance Improvement Program (QAPI) guideline dated December 2022, indicated a QMP would be implemented and documented.	0 580		

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0 580	Continued From page 6 No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 580		
0 620 SS=D	144G.42 Subd. 6 (a) Compliance with requirements for reporting ma (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) for one of one resident (R1) who had a fall with a serious injury. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On January 30, 2023, at 10:20 a.m., during entrance conference, licensed assisted living director (LALD)-C and director of nursing	0 620		

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0 620	Continued From page 7 (DON)-D stated Vulnerable Adult (VA) reporting expectations were to make a MAARC report immediately but no greater than 24 hours. R1's diagnoses included vascular dementia, cardiac pacemaker, depression, spinal stenosis, glaucoma, and recurrent falls. R1's Resident Incident Report dated July 19, 2022, indicated R1 had an unwitnessed fall. R1 was found on her kitchen floor laying on her right side. Injuries noted on the report was R1 complained of left knee pain. R1's Progress Note dated July 19, 2022, at 10:00 a.m., indicated R1 had fallen in her kitchen. R1 was found lying on her right side complaining of pain in her left knee and wanted the ambulance called. R1 did not want to move left leg or let the nurse check her out. 911 was called and R1 was transported to the emergency room (ER) for an evaluation. R1's Progress Notes dated July 19, 2022, at 2:45 p.m. indicated R1 was admitted to the hospital for surgical treatment of left femur fracture post fall. During entrance conference January 30, 2022, at approximately 10:20 a.m., LALD-C and DON-D verified to no MAARC reports were filed for the licensee in the past 6 months. On January 31, 2023, at 10:21 a.m., per the direction from the supervisor, this surveyor filed a MAARC report by telephone. On January 31, 2023, at 11:55 p.m., LALD-C and DON-D verified failure to report left femur fracture for R1. LALD-C stated she did not file the MAARC report within 24 hours because she	0 620		

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0 620	Continued From page 8 thought the incident did not meet the required reporting criteria because R1's service plan was followed. The licensee's Vulnerable Adult/Maltreatment - Communication, Prevention and Reporting policy revised October 2022, indicated mandated reporters employed by [the licensee] or providing services in the facility shall report abuse, neglect, mistreatment, misappropriation of resident property, exploitation, corporal punishment, involuntary seclusion and any physical or chemical restraints and injuries of unknown source sustained by a vulnerable adult that is not reasonably explained immediately (as soon as possible) after the discovery of the incident. Compare the incident to the "definitions" section #15 "serious bodily injury" is defined an injury involving extreme physical pain, substantial risk of death, protracted loss or impairment of the function of a bodily member, organ, or mental faculty, or requiring medical intervention such as surgery, hospitalization, or physical rehabilitation. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		
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;	0 630		

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0 630	Continued From page 9 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 interview and record review, the licensee failed to develop and implement an individual abuse prevention plan (IAPP) with required content for all identified independent living residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R6 signed the licensee's Assisted Living Contract - Independent on August 12, 2022. R6's record lacked an IAPP developed and implemented by the licensee. On January 30, 2023, at 10:00 a.m., during the entrance conference, licensed assisted living director (LALD)-C provided the licensee's Current Resident Roster: State Evaluations which listed all residents who resided at the facility. There were 67 residents who were identified as not receive services (commonly referred to as independent living) and were identified by an "X," in the column labeled, "Housing Only, No	0 630		

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0 630	Continued From page 10 services." On January 31, 2023, at approximately 1:20 p.m., director of nursing (DON)-D indicated the licensee was not aware an IAPP was required to be developed and implemented for residents who were identified as independent living. DON-D stated an IAPP was not developed for any identified independent living resident. The licensee's Individual Abuse Prevention Plan policy dated July 2021, read, "The facility must develop and implement an individualized abuse prevention plan for each vulnerable adult." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
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 be conducted as needed based on changes in the needs of the resident and cannot exceed 90	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32539	A. BUILDING: _____ B. WING _____	02/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHASKA HEIGHTS SENIOR LIVING	3120 CHESTNUT STREET NORTH CHASKA, MN 55318

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01620	Continued From page 11	01620		

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 interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident monitoring and reassessment no more than 14 days after initial assessment and failed to conduct an assessment no more than 90 days after the previous assessment for three of four residents (R3, R4, 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) 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:

R3
R3 was admitted on December 21, 2022.

R3's NEW Nursing Assessment was completed upon admission on December 21, 2022, with the next assessment due within 14 days or by January 4, 2023.

R4

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01620	Continued From page 12 R4 was admitted on August 1, 2018. R4's 90-day Comprehensive Assessment was completed on February 9, 2022, with the next assessment due within 90 days or by May 10, 2022, however, R4's record included a late 90-day assessment dated on October 28, 2022. R5 R3 was admitted on May 18, 2018. R5's 90-day Level of Care Tool was completed on July 23, 2022, with the next assessment due within 90-days or by October 21, 2022. R5's record included the next assessment to be a change of condition assessment dated on November 12, 2022. On January 31, 2023, at 4:00 p.m., licensed assisted living director (LALD)-C indicated the licensee was aware resident assessments were not completed within the required timeframes. The licensee's Comprehensive Assessment Schedule guideline dated August 2022, indicated licensee would complete assessments with the following timeframes of pre-admission, admission, 14-day, 90-day, and with change of condition of the resident. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) 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	01640		

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01640	Continued From page 13 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 interview and record review, the licensee failed to ensure the current service plan included a signature or other authentication by resident or resident representative to document agreement on the services to be provided for one of four 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 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).	01640		

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01640	Continued From page 14 The findings include: R2 was admitted on November 11, 2020. R2's Service Addendum to the Assisted Living Contract signed September 2, 2022, was identified by licensed assisted living director (LALD)-C as R2's service plan. R2's Service Addendum to the Assisted Living Contract dated January 23, 2023, was provided by LALD-C, and indicated as R2's current service plan with services R2 was receiving. The service plan included two identified services which were revised or added after the signed service plan dated September 2, 2022. On January 31, 2023, at 4:05 p.m., LALD-C indicated the licensee's expectation is all service plans are signed by the RN who completed the document and then the resident or the resident's designated representative. Director of nursing (DON)-D indicated they had completed R2's service plan but was unsure why they did not sign or obtain the resident's authentication. The licensee's Service Plan Guideline dated December 1, 2022, indicated any changes to the resident's service plan or agreement must be signed by the resident or the resident's representative and the licensee's RN. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		

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01760	Continued From page 15	01760		
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 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 medication administration was documented accurately for one of four 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 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 on November 11, 2020. R2's Services Addendum to the Assisted Living	01760		

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01760	Continued From page 16 Contract signed September 22, 2022, identified by licensed assisted living director (LALD)-C as R2's current service plan, indicated R2 received medication assist. On January 31, 2023, at approximately 10:15 a.m., the surveyor observed unlicensed personnel (ULP)-F administer Pepto Bismol (Bismuth Subsalicylate, over the counter drug for symptoms of simple digestive issues) to R2. R2's Medication Sheet for January 2023, identified by LALD-C as R2's current medication administration record (MAR), lacked Pepto Bismol as a medication to be administered or documented as administered by ULP-F. On January 31, 2023, at approximately 4:00 p.m., director of nursing (DON)-D indicated the licensee received over the weekend, a physician order on Pepto Bismol for R2, but the licensee failed to transcribe the order into R2's MAR. DON-D indicated the licensee's expectations are ULPs should only administer medications that were currently listed on the resident's MAR. The licensee's Medication & Treatments Guideline policy dated March 1, 2021, indicated licensee would complete the required documentation related to medication administration. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01880 SS=E	144G.71 Subd. 19 Storage of medications	01880		

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01880	Continued From page 17 An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were stored securely for two of four residents (R3, R7) with medication management 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, 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: R3 R3 was admitted on December 21, 2022. R3's NEW Nursing Assessment completed on December 21, 2022, identified by licensed assisted living director (LALD)-C as R3's current assessment, indicated R3's medications are stored in a locked cabinet within the apartment. R3's Services Addendum to the Assisted Living Contract signed January 10, 2023, identified by LALD-C as R3's current service plan, indicated R3 received Medication Assist.	01880		

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01880	Continued From page 18 On January 31, 2023, at approximately 9:20 a.m., the surveyor observed R3's room and noted unsecured medications stored on the counter of R3's kitchen (aspirin and acetaminophen for pain relief) and on the end table of living room (Sinex decongestive nasal spray and Refresh eye lubricating drops). Additionally, the surveyor observed unlicensed personnel (ULP)-F obtain medications out of locked cabinet in the kitchen of R3's room. R7 R7 was admitted on June 30, 2018. R7's NEW Nursing Assessment completed on October 19, 2022, identified by LALD-C as R7's current assessment, indicated R7's medications are stored in a locked cabinet within the apartment. R7's Services Addendum to the Assisted Living Contract dated January 31, 2023, identified by LALD-C as R7's current service plan, indicated R7 received Medication Assist. On January 31, 2023, at approximately 9:00 a.m., the surveyor observed R7's room and noted unsecured medications stored on the counter of R7's kitchen (chlorhexidine oral rinse for gingivitis) and on a shelf by R7's bed (Rhino nasal moisture spray, Nystatin antifungal powder, and Salonpas 4% pain relieving gel-patches). Additionally, the surveyor observed ULP-F obtain medications out of locked cabinet in kitchen of R7's room. On January 31, 2023, at approximately 4:15 p.m., LALD-C and director of nursing (DON)-D indicated residents who receive medication assist services medications would have all medications	01880		

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01880	Continued From page 19 secured in each resident's locked cabinet. The licensee's Medication & Treatments Guideline dated March 1, 2021, indicated licensee would store medications consistent with each resident's medication plan and service plan. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and	01940		

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01940	Continued From page 20 therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of two 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 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 on November 11, 2020. R2 diagnoses including urinary urgency, resulting in placement of urinary catheter (tube inserted in urethra to drain urine). R2's Services Addendum to the Assisted Living Contract signed September 22, 2022, identified by licensed assisted living director (LALD)-C as R2's current service plan, included catheter care with maintaining catheter cleanliness and changing catheter bag, but lacked documentation of procedures for notifying a registered nurse	01940		

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01940	Continued From page 21 when a problem arises with treatment services. On January 31, 2023, at approximately 9:00 a.m., unlicensed personnel (ULP)-F provided catheter care (cleaning catheter tube entering body and corresponding connected storage bag), and catheter bag change (changing overnight bag to a daily portable leg bag) to R2. On January 31, 2023, at approximately 4:15 p.m., during the exit conference, director of nursing (DON)-D acknowledged R2's records lacked all the required content for R2's treatment management plan. DON-D indicated the licensee was not aware of all the required content for a treatment management plan. DON-D stated although the ULP contacts the RN when a problem arose, R2's record lacked when the ULP should contact the RN when treatment problems arise. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an	02040		

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02040	Continued From page 22 approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide hazard vulnerability assessment or safety risk assessment of the physical environment on and around the property for the facility. 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, 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). Findings include: A record review and interview were conducted on February 01, 2023, between approximately 10:05 a.m. and 12:39 p.m. with Licensed Assisted Living Director (LALD)-C and Maintenance (M)-H on the hazard vulnerability assessment for the physical environment of the facility. Record review indicated that the licensee had not performed a hazard vulnerability assessment with mitigation factors on and around the property. During interview, LALD-C stated that the licensee had performed a hazard assessment for the Appendix Z requirements but had not performed a hazard vulnerability assessment for the physical environment on or around the property and did not have any mitigation factors listed.	02040		

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02040	Continued From page 23 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
03000 SS=D	626.557 Subd. 3 Timing of report (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause	03000		

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03000	Continued From page 24 (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) for one of one resident (R1) who had a fall with a serious injury. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On January 30, 2023, at 10:20 a.m., during entrance conference, licensed assisted living director (LALD)-C and director of nursing (DON)-D stated Vulnerable Adult (VA) reporting	03000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32539	A. BUILDING: _____ B. WING _____	02/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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03000	Continued From page 25 expectations were to make a MAARC report immediately but no greater than 24 hours. R1's diagnoses included vascular dementia, cardiac pacemaker, depression, spinal stenosis, glaucoma, and recurrent falls. R1's Resident Incident Report dated July 19, 2022, indicated R1 had an unwitnessed fall. R1 was found on her kitchen floor laying on her right side. Injuries noted on the report was R1 complained of left knee pain. R1's Progress Note dated July 19, 2022, at 10:00 a.m., indicated R1 had fallen in her kitchen. R1 was found lying on her right side complaining of pain in her left knee and wanted the ambulance called. R1 did not want to move left leg or let the nurse check her out. 911 was called and R1 was transported to the emergency room (ER) for an evaluation. R1's Progress Notes dated July 19, 2022, at 2:45 p.m. indicated R1 was admitted to the hospital for surgical treatment of left femur fracture post fall. During entrance conference January 30, 2022, at approximately 10:20 a.m., LALD-C and DON-D verified to no MAARC reports were filed for the licensee in the past 6 months. On January 31, 2023, at 10:21 a.m., per the direction from the supervisor, this surveyor filed a MAARC report by telephone. On January 31, 2023, at 11:55 p.m., LALD-C and DON-D verified failure to report left femur fracture for R1. LALD-C stated she did not file the MAARC report within 24 hours because she thought the incident did not meet the required	03000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32539	A. BUILDING: _____ B. WING _____	02/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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03000	Continued From page 26 reporting criteria because R1's service plan was followed. The licensee's Vulnerable Adult/Maltreatment - Communication, Prevention and Reporting policy revised October 2022, indicated mandated reporters employed by [the licensee] or providing services in the facility shall report abuse, neglect, mistreatment, misappropriation of resident property, exploitation, corporal punishment, involuntary seclusion and any physical or chemical restraints and injuries of unknown source sustained by a vulnerable adult that is not reasonably explained immediately (as soon as possible) after the discovery of the incident. Compare the incident to the "definitions" section #15 "serious bodily injury" is defined an injury involving extreme physical pain, substantial risk of death, protracted loss or impairment of the function of a bodily member, organ, or mental faculty, or requiring medical intervention such as surgery, hospitalization, or physical rehabilitation. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	03000		

Minnesota Department of Health

625 Robert Street North
St Paul
651-201-4500

Type: Full
Date: *01/30/23*
Time: 11:53:49
Report: 7994231025

Food and Beverage Establishment Inspection Report

Location:
Chaska Heights Senior Living
3120 Chestnut Street North
Chaska, MN55318
Carver County, 10

Establishment Info:
ID #: 0038300
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9523616100
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.

No NEW orders were issued during this inspection.

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

THIS VISIT WAS CONDUCTED AS PART OF AN HRD SURVEY. THE FOOD SERVICE IS BEING CONDUCTED BY A CONTRACTED COMPANY, (CURA). PER THE CURRENT HRD POLICY THIS FACILITY WILL BE ISSUED A LICENSE FROM THE LOCAL LICENSING AUTHORITY (MDH).

A MDH LICENSE WAS PREVIOUSLY ACTIVE AT THIS LOCATION WHICH WILL BE REISSUED SHORTLY. ONCE THAT PROCESS IS COMPLETE THE ROUTINE MDH INSPECTION WILL BE CONDUCTED.

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 7994231025 of 01/30/23.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Signed:_____
Establishment Representative

Signed: Crystal Elva
Crystal Elva
Public Health Sanitarian 3
St Paul
651-201-3981
Crystal.Elva@state.mn.us