Electronically Delivered

September 26, 2024

Licensee
Ashton Homes LLC
6242 Larch Lane North
Maple Grove, MN 55369

RE: Project Number(s) SL34920015

Dear Licensee:

On August 27, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the May 30, 2024, 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 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: 1-866-890-9290

HHH

Electronically Delivered

July 2, 2024

Licensee
Ashton Homes LLC
6242 Larch Lane North
Maple Grove, MN 55369

RE: Project Number(s) SL34920015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on May 30, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH 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.

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. MDH 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 may be 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.31, Subd. 4(a)(5), MDH may impose fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. MDH may impose 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. MDH also may impose a

fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

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

0820 - 144g.45 Subd. 2 (g) - Fire Protection And Physical Environment - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **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
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

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

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

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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. to submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

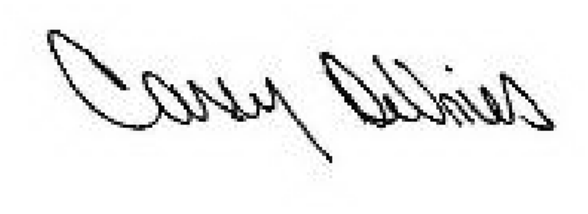
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,



Casey DeVries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34920	A. BUILDING: _____ B. WING _____	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHTON HOMES LLC	6242 LARCH LANE NORTH MAPLE GROVE, MN 55369

(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: SL34920015-0 On May 28, 2024, through May 30, 2024, the Minnesota Department of Health conducted an initial survey at the above provider, and the following correction orders are issued. At the time of the survey, there were four residents all of whom received services under the provider's Assisted Living license. An immediate correction order was identified on May 29, 2024, issued for SL34920015-0, tag identification 0820. On May 29, 2024, the immediacy of correction order 0820 was removed, however non-compliance remained, and the scope and level remained unchanged.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness	0 680		

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0 680	Continued From page 1 (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	0 680		

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0 680	Continued From page 2 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's emergency disaster preparedness plan lacked evidence of the following required content: - annual update; - quarterly review of missing resident policy; - subsistence needs for staff and patients to include sewage and waste disposal; and - emergency officials contact information to include Minnesota Office of Ombudsman for Long Term Care (OOLTC). On May 29, 2024, at 10:07 a.m., licensed assisted living director (LALD)-D stated the EPP was created on April 3, 2023, when they acquired the assisted living, and they forgot to write the date of the annual review. LALD-D stated they believed the missing resident policy needed to be reviewed annually. LALD-D stated the EPP was missing sewage and waste disposal however, if there was a concern, they would contact maintenance. LALD-D stated the licensee did not have the number for OOLTC in the EPP because the licensee posted the number on the wall. The licensee's Emergency and Disaster Preparedness policy dated July 1, 2023, the licensee would be prepared to manage emergency and disaster situations including missing residents through their hazard vulnerability assessment and emergency planning. In addition, a written policy and procedure regarding missing resident is complete and in compliance with MN Rule 4659.0110	0 680		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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0 680	Continued From page 3 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide documentation of monthly inspections of all the fire extinguishers. This deficient condition had the ability to affect all staff and 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, 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	0 790		

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0 790	Continued From page 4 a large portion or all of the residents). Findings include: On May 28, 2024, survey staff conducted a facility tour with clinical nurse supervisor (CNS)-C, survey staff observed that the fire extinguishers throughout the facility did not have documentation of monthly inspections. Monthly inspections of the fire extinguishers are required to ensure that all systems are maintained and remain in working order. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
0 820 SS=I	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide properly sized egress window for resident rooms that did not create a distinct	0 820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34920	A. BUILDING: _____ B. WING _____	05/30/2024

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ASHTON HOMES LLC	6242 LARCH LANE NORTH MAPLE GROVE, MN 55369

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0 820	Continued From page 5 hazard for residents. This had the potential to directly affect a portion of the residents and staff. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On May 28, 2024, at 1:15 p.m., survey staff conducted a facility tour with clinical nurse supervisor (CNS)-C. During facility tour, survey staff observed the following: Survey staff measured and verified egress window measurement of the openable area to be 16.75" high x 25.5" wide for a total of 427.125 square inches in occupied resident room #1. Survey staff measured and verified egress window measurement of the openable area to be 16.5" high x 25.5" wide for a total of 420.75 square inches in occupied resident room #2. Survey staff measured and verified egress window measurement of the openable area to be 13" high x 25.5" wide for a total of 331.5 square inches in occupied resident room #4. Survey staff measured and verified egress window measurement of the openable area to be 12.5" high x 25.5" wide for a total of 318.75 square inches in unoccupied resident room #3.	0 820		

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0 820	Continued From page 6 Egress windows in existing facilities must have a minimum opening dimension of 648 square inches with an opening height and width dimension of no less than 20". TIME PERIOD FOR CORRECTION: Immediate On May 29, 2024, the immediacy of correction order 0820 was removed, however non-compliance remained, and the scope and level remained unchanged.	0 820		
01370 SS=F	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating;	01370		

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	34920	A. BUILDING: _____ B. WING _____	05/30/2024

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01370	Continued From page 7 (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency evaluations were completed for all required skill areas, prior to providing services, for one of one unlicensed personnel (unlicensed personnel/housing manager (ULP/HM)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: ULP/HM-B began employment with the licensee on April 3, 2023, to provide direct cares and services.	01370		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34920	A. BUILDING: _____ B. WING _____	05/30/2024

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01370	Continued From page 8 On May 29, 2024, at 7:08 a.m., the surveyor observed ULP/HM-B administer oral medications to R1. ULP/HM-B's employee record lacked the following competency evaluations: -care of teeth, gums, and oral prosthetic devices; -care and use of hearing aids; and -dressing and assisting with toileting. On May 28, 2024, at 1:37 p.m., clinical nurse supervisor (CNS)-C stated the licensee previously did not train on the topics listed above because the licensee did not provide the cares and services at the facility however, during a survey located at a sister facility, a surveyor reviewed the statues related to the items listed above. CNS-C stated since the sister facility's survey, the licensee updated their training form, however, had not completed the training with all of the ULP. The surveyor inquired how many ULPs CNS-C still needed to complete the topics listed above. CNS-C stated more than ten ULP still needed to complete the competencies. The licensee's Assisted Living Orientation- ULP Staff dated January 1, 2024, indicated ULP who are not nurse assistant registered (NAR) would receive additional training with a written or oral competency test and a skill demonstration for care of teeth, gums, and oral prosthetic devices, care and use of hearing aids, dressing, and toileting assistance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34920	A. BUILDING: _____ B. WING _____	05/30/2024

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01380	Continued From page 9	01380		
01380 SS=F	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency evaluations were completed for all required skill areas, prior to providing services, for one of one unlicensed personnel (unlicensed personnel/housing manager (ULP/HM)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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).	01380		

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01380	Continued From page 10 The findings include: ULP/HM-B began employment with the licensee on April 3, 2023, to provide direct cares and services. On May 29, 2024, at 7:08 a.m., the surveyor observed ULP/HM-B administer oral medications to R1. ULP/HM-B's employee record lacked the following competency evaluations: -range of motion. On May 28, 2024, at 1:37 p.m., clinical nurse supervisor (CNS)-C stated the licensee previously did not train on the topics listed above because the licensee did not provide the cares and services at the facility however, during a survey located at a sister facility, a surveyor reviewed the statues related to the items listed above. CNS-C stated since the sister facility's survey, the licensee updated their training form, however, had not completed the training with all of the ULP. The surveyor inquired how many ULPs CNS-C still needed to complete the topics listed above. CNS-C stated more than ten ULP still needed to complete the competencies. The licensee's Assisted Living Orientation- ULP Staff dated January 1, 2024, indicated ULP who are not nurse assistant registered (NAR) would receive additional training with a written or oral competency test and a skill demonstration for range of motion. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		

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ASHTON HOMES LLC	6242 LARCH LANE NORTH MAPLE GROVE, MN 55369

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01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan included all required content for three of three residents (R2, R3, R5). This practice resulted in a level two violation (a	01650		

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01650	Continued From page 12 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: R2 R2 admitted to the licensee on April 22, 2022, and began receiving assisted living services. R2's Assisted Living Service Plan (SP) signed February 27, 2024, indicated R2 received assistance with housekeeping, shopping, meals, transportation, money management, socialization, dressing, grooming, bathing, ambulating, medication administration, and behavior management. R3 R3 admitted to the licensee on April 17, 2024, and began receiving assisted living services. R3's Assisted Living Service Plan (SP) signed April 17, 2024, indicated R3 received assistance with housekeeping, shopping, meals, transportation, money management, socialization, dressing, grooming, bathing, medication administration, and behavior management. R5 R5 admitted to the licensee on April 30, 2024, and began receiving assisted living services. R5's Assisted Living Service Plan (SP) signed April 30, 2024, indicated R5 received assistance	01650		

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01650	Continued From page 13 with housekeeping, shopping, meals, transportation, socialization, dressing, grooming, bathing, medication administration, and behavior management. R2, R3, and R5's service plan lacked the following content: - methods of monitoring assessments of the resident. On May 28, 2024, at 2:13 p.m., clinical nurse supervisor (CNS)-C stated resident assessments were "mostly" completed in person. CNS-C stated the service plan did not have the method for assessment because the only time they would complete an assessment over the telephone would be if the resident was not available. The licensee's Contents of Service Plans policy dated January 1, 2024, indicated the service plan would include schedule and methods of monitoring assessments. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's	01730		

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01730	Continued From page 14 assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and maintain a current individualized medication management record for each resident to include all required content for one of four residents (R1).	01730		

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01730	Continued From page 15 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 admitted to the licensee on April 22, 2022, and began receiving assisted living services. R2's Assisted Living Service Plan (SP) signed February 27, 2024, indicated R2 received assistance with housekeeping, shopping, meals, transportation, money management, socialization, dressing, grooming, bathing, ambulating, medication administration, and behavior management. On May 29, 2024, at 7:08 a.m., the surveyor observed ULP/HM-B place seven medications including aspirin 81 mg chewable tablet into a medication cup. ULP/HM-B handed the medication cup to R2 and instructed them to take the medication. The surveyor observed R2 place all medications from the medication cup into their hand and swallow the medication with liquid. The surveyor did not observe ULP/HM-B instruct R2 to chew the aspirin 81 mg prior to swallowing. R2's Medication Administration Record (MAR) dated May 1, 2024, through May 31, 2024, read, "ASPIRIN CHW 81 MG (ST JOSEPH ASPIRIN) TAKE ONE TABLET BY MOUTH EVERY MORNING FOR: Essential (primary)	01730		

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01730	Continued From page 16 hypertension." The MAR lacked specific administration instructions that included whether a medication should be chewed prior to swallowing when administered. On May 29, 2024, at 9:39 a.m., the surveyor asked ULP/HM-B to look at the aspirin chewable blister card. The surveyor observed a sticker that read chew tablets before swallowing. The surveyor inquired how ULP/HM-B administered aspirin chewable. ULP/HM-B stated they put all oral medications together in the medication cup and instruct R2 to swallow the medication. The surveyor showed ULP/HM-B the sticker on the aspirin blister card. ULP/HM-B stated they were unaware because the MAR did not instruct them to do that. On May 29, 2024, at 12:22 p.m., clinical nurse supervisor (CNS)-C verified the MAR lacked instructions for the resident to chew the tablet and stated it was missed. CNS-C stated the section in the MAR where resident specific instructions should be located, would not allow nursing to edit the section to place instructions and they would contact someone to receive assistance. The licensee's Administration of Medication, Treatment and Therapy by Unlicensed Personnel dated January 1, 2024, read, "The RN may delegate to unlicensed personnel the task of providing assistance with self-administration of medications or may delegate administration of medications, treatment and therapy if the unlicensed personnel have satisfied the training requirements listed above if: a. Before performing the procedures, the RN has instructed the unlicensed personnel in the proper methods to administer the medications, treatment and therapy and the unlicensed personnel have	01730		

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01730	Continued From page 17 demonstrated the ability to competently follow the procedures; b. The RN has developed written, specific instruction for each client [resident]." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
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 each medication administered by the assisted living staff was documented in the resident record for one of four residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	01760		

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01760	Continued From page 18 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: R3 admitted to the licensee on April 17, 2024, and began receiving assisted living services. R3's Assisted Living Service Plan (SP) signed April 17, 2024, indicated R3 received assistance with housekeeping, shopping, meals, transportation, money management, socialization, dressing, grooming, bathing, medication administration, and behavior management. On May 29, 2024, at 7:21 a.m., the surveyor observed R3 request "ibuprofen" for pain to unlicensed personnel/housing manager (ULP/HM-B). ULP/HM-B stated when R3 reported pain the nurse instructed ULP to administer acetaminophen however, the order was not in the computer system (Point of Care (POC) (a documenting software system). The surveyor then observed ULP/HM-B remove a blister card of acetaminophen 325 milligrams (mg) with two tablets in each blister. ULP-B punched out two tablets of acetaminophen 325 mg into the medication cup which contained R3's morning medication. ULP/HM-B handed medication cup to R3, R3 took all medications at once, ULP/HM-B returned to the medication cart, opened the electronic medication record (EMAR), and documented on R3's morning medications. The surveyor did not observe ULP/HM-B call the nurse for administration instructions related to acetaminophen prior to administration, an order	01760		

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01760	Continued From page 19 for acetaminophen in the EMAR, or see ULP/HM-B document on the administration of acetaminophen to R3. On May 29, 2024, at 9:31 a.m., ULP/HM-B stated they were trained to document as needed (PRN) medications including over the counter (OTC) medication on the EMAR and after a period of time they would go back onto the computer system and document the effectiveness of the medication. ULP/HM-B stated the nurse trained them to use the blister card of acetaminophen for R3 when they were in pain. ULP/HM-B stated they did not document on administering acetaminophen to R3 however, they did notify the nurse. ULP/HM-C stated the nurse told them the order was not in the computer system and nursing would update it. On May 29, 2024, at 12:16 p.m., clinical nurse supervisor (CNS)-C stated ULP were trained when they administered PRN medication to compare the medication to the order listed in POC to ensure the medication can be given at the time they were attempting to administer it. CNS-C stated if the medication could not be given because it was too close to the previous medication administration, ULP were trained to contact a nurse for further instructions. CNS-C stated all medications administered by staff needed to have an order in the EMAR in POC prior to administration. CNS-C stated staff and residents were educated if there was an OTC medication being administered the licensee, the licensee would need to obtain a prescriber order prior to staff dispensing the medication. CNS-C stated R3 moved into the facility in April 2024, and they believe R3 medication blister card was transferred from R3's previous facility.	01760		

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01760	Continued From page 20 On May 30, 2024, at 9:31 a.m., via email, owner (O)-E wrote, "We don't distinguish between OTC and PRN. Our PRN policy guides how we handle as needed med. As such we don't have an OTC med policy." The licensee's Administration and documentation of PRN Medications policy dated June 1, 2023, indicated PRN medications would be administered consistent with the parameters specified in the prescriber's prescription and with the procedures identified by the RN for the administration and documentation of the PRN. In addition, staff would administer PRN medications exactly as prescribed and would document administration of PRN medications on the form required by the RN. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01800 SS=D	144G.71 Subd. 11 Prescribed and nonprescribed medication The assisted living facility must determine whether the facility shall require a prescription for all medications the provider manages. The facility must inform the resident whether the facility requires a prescription for all over-the-counter and dietary supplements before the facility agrees to manage those medications. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to determine whether the licensee shall require a prescription for all	01800		

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01800	Continued From page 21 over-the counter (OTC) medications provided by the assisted living staff prior to managing the medication for one of four residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: R3 admitted to the licensee on April 17, 2024, and began receiving assisted living services. R3's Assisted Living Service Plan (SP) signed April 17, 2024, indicated R3 received assistance with housekeeping, shopping, meals, transportation, money management, socialization, dressing, grooming, bathing, medication administration, and behavior management. On May 29, 2024, at 7:21 a.m., the surveyor observed R3 request "ibuprofen" for pain to unlicensed personnel/housing manager (ULP/HM-B). ULP/HM-B stated when R3 reported pain the nurse instructed ULP to administer acetaminophen however, the order was not in the computer system (Point of Care (POC) (a documenting software system). The surveyor then observed ULP/HM-B remove a blister card of acetaminophen 325 milligrams (mg) with two tablets in each blister. ULP-B punched out two tablets of acetaminophen 325 mg into the medication cup which contained R3's morning medication. ULP/HM-B handed medication cup to	01800		

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01800	Continued From page 22 R3, R3 took all medications at once, ULP/HM-B returned to the medication cart, opened the electronic medication record (EMAR), and documented on R3's morning medications. The surveyor did not observe ULP/HM-B call the nurse for administration instructions related to acetaminophen prior to administration, an order for acetaminophen in the EMAR, or see ULP/HM-B document on the administration of acetaminophen to R3. R3's medical record lacked a prescriber order for acetaminophen. On May 29, 2024, at 9:31 a.m., ULP/HM-B stated they were trained to document as needed (PRN) medications including OTC medication on the EMAR and after a period of time they would go back onto the computer system and document the effectiveness of the medication. ULP/HM-B stated the nurse trained them to use the blister card of acetaminophen for R3 when they were in pain. ULP/HM-B stated they did not document on administering acetaminophen to R3 however, they did notify the nurse. ULP/HM-C stated the nurse told them the order was not in the computer system and nursing would update it. On May 29, 2024, at 12:16 p.m., clinical nurse supervisor (CNS)-C stated ULP were trained when they administered PRN medication to compare the medication to the order listed in POC to ensure the medication can be given at the time they were attempting to administer it. CNS-C stated if the medication could not be given because it was too close to the previous medication administration, ULP were trained to contact a nurse for further instructions. CNS-C stated all medications administered by staff needed to have an order in the EMAR in POC	01800		

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01800	Continued From page 23 prior to administration. CNS-C stated staff and residents were educated if there was an OTC medication being administered the licensee, the licensee would need to obtain a prescriber order prior to staff dispensing the medication. CNS-C stated R3 moved into the facility in April 2024, and they believe R3 medication blister card was transferred from R3's previous facility. On May 30, 2024, at 9:31 a.m., via email, owner (O)-E wrote, "We don't distinguish between OTC and PRN. Our PRN policy guides how we handle as needed med. As such we don't have an OTC med policy." The licensee's Administration and documentation of PRN Medications policy dated June 1, 2023, indicated PRN medications would be administered consistent with the parameters specified in the prescriber's prescription and with the procedures identified by the RN for the administration and documentation of the PRN. In addition, staff would administer PRN medications exactly as prescribed and would document administration of PRN medications on the form required by the RN. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01800		
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a	01910		

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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
01910	Continued From page 24 resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide documentation in the resident's record regarding the disposition of medication to include medication's name, strength, prescription number as applicable, quantity, date of disposition, to whom the medications were given, and names of staff and other individuals involved in the disposition for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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:	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34920	A. BUILDING: _____ B. WING _____	05/30/2024

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ASHTON HOMES LLC	6242 LARCH LANE NORTH MAPLE GROVE, MN 55369

(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
01910	Continued From page 25 R1 was discharged to a sister facility of the licensee on October 28, 2023. R1's diagnoses included major depression, paranoid schizophrenia, attention deficit disorder (ADD), anxiety disorder, delusional disorder, post-traumatic stress disorder (PTSD), diabetes mellitus type two, cannabis dependence, cocaine abuse, and hypertension (HTN). R1's Assisted Living Service Plan (SP) signed April 3, 2023, indicated R1 received assistance with homemaking, shopping, meals, transportation, money management, socialization, dressing, grooming, bathing, medication management including insulin injections, and behavior management. R1's Medication Administration Record dated October 1, 2023, through October 31, 2023, indicated the licensee administered atorvastatin 40 milligrams (mg) daily, escitalopram 10mg daily, gabapentin 300 mg three times daily, glyburide 2.5 mg daily, Humalog 8 units (u) three times daily, Lantus 34 u daily, Cozaar 50 mg daily, metformin 1000 mg twice daily, olanzapine 20 mg twice daily, prazosin 2 mg daily, Pulmicort 90 microgram (mcg) inhaler twice daily, and varenicline 1 mg twice daily. R1's undated Discharge Summary, indicated all medications were transferred to a new home and were locked in a medication cart. R1's record lacked a medication disposition that included medication's name, strength, prescription number as applicable, quantity, date of disposition, to whom the medications were given, and names of staff and other individuals	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34920	A. BUILDING: _____ B. WING _____	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHTON HOMES LLC	6242 LARCH LANE NORTH MAPLE GROVE, MN 55369

(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
01910	Continued From page 26 involved in the disposition. On May 29, 2024, at 12:12 p.m., the surveyor inquired if the licensee documented the medication name, or the amount of medication provided to the resident and/or resident representative when a resident transfers to a different facility. Clinical nurse supervisor (CNS)-C stated no, when residents were transferred to a new facility the licensee wrote a "blanket statement" on the discharge summary that indicated all medications had been transferred. The licensee's Disposition or Disposal of Medication dated January 1, 2024, indicated current medications that are secured or stored by the licensee would be given to the resident or the resident representative when the resident's medication management services are terminated, except that the conditions listed below must be met before controlled medications belonging to a resident will be given to the resident or resident's representative. The licensee would document in the resident's record the name of the person to whom the medications where given, the time and date, the name of each medication and the amount of medication remaining. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		

Minnesota Department of Health

625 North Robert Street
Saint Paul, MN
651-201-5000

Type: Full
Date: *05/28/24*
Time: 12:30:00
Report: 8087241135

Food and Beverage Establishment Inspection Report

Location:
Ashton Homes Llc
6242 Larch Lane North
Maple Grove, MN55369
Hennepin County, 27

Establishment Info:
ID #: 0038148
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7637771059
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.

Food and Equipment Temperatures

Process/Item: Ambient Air
Temperature: 10 Degrees Fahrenheit - Location: STAND-UP FREEZER
Violation Issued: No

Process/Item: Ambient Air
Temperature: 40 Degrees Fahrenheit - Location: STAND-UP REFRIGERATOR
Violation Issued: No

Process/Item: Cold Holding: MILK
Temperature: 36 Degrees Fahrenheit - Location: STAND-UP REFRIGERATOR
Violation Issued: No

Process/Item: Cold Holding: YOGURT
Temperature: 39 Degrees Fahrenheit - Location: STAND-UP REFRIGERATOR
Violation Issued: No

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

THIS WAS AN ANNOUNCED AND SCHEDULED FULL INSPECTION.

INSPECTION CONDUCTED IN THE PRESENCE OF NURSE EVALUATOR ASHLEY CREWS.

FLOORS AND CABINETS ARE HARDWOOD AND CEILING IS KNOCK DOWN, WHICH NOT SMOOTH IN TEXTURE NOR EASILY CLEANABLE. ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT SUCH A TIME THEY ARE FOUND TO BE A CONCERN OR RISK OF CONTAMINATION, THEY WILL BE ORDERED TO BE REPLACED AND BROUGHT UP TO CODE.

WHIRLPOOL BRAND DISHWASHER IS RESIDENTIAL BUT HAS SANITIZING RINSE CYCLE

OPTION. TEMPERATURE LOG SHOWS DISHWASHER REGULARLY REACHES 160 DEGREES.

HOT WATER TEMPERATURE AT THE KITCHEN SINK REACHED 120 DEGREES.

DESIGNATED HAND WASHING SINK IN THE KITCHEN (RIGHT SIDE OF 2-BIN, CERAMIC, RESIDENTIAL KITCHEN SINK).

INSPECTION REPORT EMAILED TO NURSE EVALUATOR ASHLEY CREWS.

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 8087241135 of 05/28/24.

Certified Food Protection Manager: ANNA ROLLAGE

Certification Number: FM122088 Expires: 03/19/27

Inspection report reviewed with person in charge and emailed.

Signed: _____

ANNA ROLLAG
HOUSE MANAGER

Signed: _____

John Boettcher
Public Health Sanitarian 3
St. Paul, MN / Freeman
651-201-5076
john.boettcher@state.mn.us