Electronically Delivered

November 13, 2023

Licensee
Legend Health Care Resources
2240 Idle Court
Maplewood, MN 55109

RE: Project Number(s) SL37108015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on November 2, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the 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. The 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 . . ."

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

DOCUMENTATION OF ACTION TO COMPLY
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 the MDH within 15 calendar days of the correction order receipt date.

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

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

Please address your cover letter for reconsideration requests to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
HRD 3A, 3rd Floor
P.O. Box 64900
625 Robert Street North
St. Paul, MN 55164

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,

Jodi Johnson, Supervisor
State Evaluation Team
Email: jodi.jonson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37108	A. BUILDING: _____ B. WING _____	11/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGEND HEALTH CARE RESOURCES	2240 IDLE COURT MAPLEWOOD, MN 55109

(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: SL37108015-0 On October 30, 2023, through November 2, 2023, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were no active residents; no residents were receiving services under the Assisted Living license.	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 License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 110 SS=C	144G.10 Subdivision 1a Assisted living director license required Each assisted living facility must employ an	0 110		

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0 110	Continued From page 1 assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports.? This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A was listed as the Director of Record for the licensee. This had the potential to affect all the licensee's residents, staff, and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On October 30, 2023, the Minnesota Board of Executives for Long-Term Services and Support (BELTSS) website indicated LALD/CNS-A currently held a LALD license effective through October 31, 2023; however, LALD/CNS-A's license lacked an organization listed as the Director of Record for the licensee. On October 30, 2023, at 3:24 p.m. the evaluator emailed a BELTSS representative to clarify LALD/CNS-A's status as director of record for the facility. At 4:29 p.m., the BELTSS representative responded, "This individual is not listed, and we do not have anyone listed as the Director of Record. They did renew their license, and included with those instructions for renewals,	0 110		

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0 110	Continued From page 2 included reminders and instructions how to update the Director of Record. I will reach out to let them know how to get the facility added under their license." On October 31, 2023, at 9:15 a.m. LALD/CNS-A stated he had renewed his LALD license but was having trouble figuring out how to get listed as the licensee's director of record on the BELTSS website. He stated he did find an email that morning from the BELTSS representative and would follow up with completion of this requirement. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health.	0 550		

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0 550	Continued From page 3 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post the required information related to the grievance procedure as well as the required information related to the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On October 30, 2023, at 2:20 p.m. during a facility review of postings, the surveyor noted various postings on two bulletin boards on the upper level of the facility. The postings lacked the required information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. Additionally, the posting lacked contact information for the Office of Ombudsman for Mental Health and Developmental Disabilities and lacked information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center.	0 550		

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0 550	Continued From page 4 On October 30, 2023, at 2:25 p.m. licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee usually gave the residents the forms; however, he had not posted the information in a conspicuous location as required. The licensee's Complaint/Grievance policy dated August 1, 2021, indicated [licensee name] will post, in a conspicuous place, information about our complaint/ grievance procedure, and the name, telephone number, and email contact information for the individual(s) who are responsible for handling resident complaint/grievances. The posting will also have the contact information for the Office of Ombudsman for Long Term Care and the Ombudsman for Mental Health and Developmental Disabilities. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 570 SS=C	144G.42 Subdivision 1 Display of license The original current license must be displayed at the main entrance of each assisted living facility. The facility must provide a copy of the license to any person who requests it. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to display the original current license at the main entrance of the assisted living facility as required. This had the potential to affect all the	0 570		

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0 570	Continued From page 5 licensee's current residents, staff, and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: On October 30, 2023, at 2:20 p.m. the surveyor observed the facility entrance area with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A, and noted the license was not posted as required. LALD/CNS-A stated the license was posted in his office area on the lower level of the facility. The license posted was dated August 1, 2022, through May 31, 2023. The surveyor confirmed the facility license was renewed and was dated June 1, 2023, through May 31, 2024, but was not posted in the facility. LALD/CNS-A stated he was not aware he needed to post the facility license in the main entrance of the facility. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 570		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and	0 640		

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0 640	Continued From page 6 suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to support protection and safety by not posting information and phone numbers for reporting to the Minnesota Adult Abuse Reporting Center (MAARC) as required. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On October 30, 2023, at 2:20 p.m. the surveyor observed postings on the upper/main level of the facility and noted the facility lacked the required information and phone numbers for reporting to MAARC. On October 30, 2023, at 2:25 p.m. licensed	0 640		

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0 640	Continued From page 7 assisted living director/clinical nurse supervisor (LALD/CNS)-A stated he had not realized the requirement to post this information. The licensee's Vulnerable Adult Maltreatment Prevention and Reporting policy dated August 1, 2021, indicated [licensee name] will post information for reporting suspected crime and maltreatment. The facility will support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding	0 680		

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0 680	Continued From page 8 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 observation, interview, and record review the licensee failed to develop an all-hazards risk assessment emergency preparedness (EP) program and plan to include Appendix Z required elements and failed to post the plan prominently. In addition, the licensee failed to post clearly written emergency exit diagrams. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: During a tour of the facility on October 30, 2023, at 2:20 p.m., the surveyor observed postings on the wall of each floor of the two-level facility. The lower level of the facility included an enlarged	0 680		

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0 680	Continued From page 9 floor plan that included defined exits but lacked identification of each room and an established route to the exits. The upper level of the facility lacked the posting of an exit plan. On October 30, 2023, at 2:25 p.m. owner (O)-B stated he understood the diagram posted on the lower level was unclear with respect to the identification of each room and the upper level lacked an exit plan. O-B stated he was in contact with the contractor who provided the floor plan and would have it modified to include the required content. On October 31, 2023, at 3:00 p.m. the surveyor reviewed the licensee's EP plan. The plan was developed by an outside agency to include some basic content but lacked completeness or facility specific details with the plan. The licensee lacked the following required information according to Emergency Preparedness: Appendix Z: - identification of at-risk population needs like maintaining independence, communication, transportation, supervision, medical care; and qualified person authorized in writing to act in the absence of the administrator; - a process for cooperation and collaboration with local, tribal, regional, State and Federal EP to maintain integrated response; - policy and procedure based on the EP risk assessment and communication plan; - policy and procedure addressing whether evacuated or shelter in place for staff/residents for food, water, medical supplies, pharmaceutical supplies; - policy and procedure addressing alternate sources of energy to maintain temperatures to protect resident health/safety, safe and sanitary	0 680		

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0 680	Continued From page 10 storage of provisions emergency lighting and sewage and waste disposal; - policy and procedure for a system to track the location of on duty staff and sheltered residents and if on duty staff and sheltered residents are relocated, the facility must document the specific name/location of the receiving facility or other location; - policy and procedure addressing safe evacuation form facility, including care and treatment needs of evacuees; staff responsibilities; primary/alternate communication means with external sources of assistance; - policy and procedure to shelter in place for residents, staff, and volunteers who remain in the facility; - policy and procedure addressing system of medical documentation that preserves resident information, protects confidentiality, and secures/maintains availability of records; - policy and procedures addressing development of arrangements with other facilities/providers to receive residents in the event of limitations/cessation of operations to maintain the continuity of services to residents; - develop a written communication plan; - communication plan which includes names/contact information: staff, entities providing services under agreement, residents' physicians, other facilities, volunteers; - communication plan which includes contact information for Federal, State, tribal, regional, and local EP staff; State Licensing and Certification Agency; and other sources of assistance; - communication plan which includes alternate means of communication with facility staff and Federal, State, tribal, regional, and local emergency management agencies; - communication plan which includes method for sharing information and medical documentation	0 680		

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0 680	Continued From page 11 for residents under the facility's care, as necessary, with other health care personnel to maintain continuity of care; means, in event of evacuation, to release resident information as permitted under 45 CFR 164.510(b)(1)(ii); means of providing information about general condition/location of residents under facility's care as permitted under 45 CFR 164.510(b)(4); - communication plan which includes means to providing information about the facility occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the incident command center, or designee; and - training program which includes initial training in EP policy and procedure to all new and existing staff, individuals providing services under arrangement, volunteers consistent with their expected role; provide EP training at least annually; maintain documentation of all EP training; demonstrate staff knowledge of EP; - conduct exercises to test EP at least twice per year, including unannounced staff drills using EP, including participating in an annual full-scale exercise community based or annual individual facility based functional exercise or if facility experiences an actual emergency requiring evacuation of plan, facility is exempt from engaging in its next required full scale exercise; conduct an additional annual exercise that may include a second full scale exercise community based or an individual; facility based functional exercise or mock disaster drill or table top exercise. On October 31, 2023, at 3:30 p.m. LALD/CNS-A stated the owner oversaw the EP plan and had purchased the plan from an outside entity. He stated the licensee had not reviewed the content of the EP plan on an annual basis, nor had they exercised their plan as it was currently written. He	0 680		

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0 680	Continued From page 12 stated he had talked to the owner and had discussed the need for more facility specific training and practice of their EP plan, but that had not yet occurred. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 720 SS=D	144G.43 Subd. 2 Access to records The facility must ensure that the appropriate records are readily available to employees and contractors authorized to access the records. Resident records must be maintained in a manner that allows for timely access, printing, or transmission of the records. The records must be made readily available to the commissioner upon request. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure that the appropriate records for one of one resident (R1) were readily available for timely access to employees, vendors, and the commissioner authorized to access the records. 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).	0 720		

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0 720	Continued From page 13 The findings include: On October 30, 2023, at 12:15 p.m. during the entrance conference, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee used Residex as their electronic medical record (EMR) system for all resident documentation. He stated he had some difficulty in the past with accessing certain records from the EMR system after a resident discharged. R1 was discharged from the facility on August 1, 2023. On October 30, 2023, at 2:30 p.m. the surveyor requested R1's records to include R1's treatment plan, medication administration record (MAR) and treatment administration record (TAR) for June 2023. On October 30, 2023, at 9:52 p.m. LALD/CNS-A emailed a copy of R1's medication list dated "as of October 30, 2023," but not the June 2023, MAR as requested. On October 31, 2023, at 11:45 a.m. the surveyor again requested R1's MAR dated for June 2023, and again LALD/RN-A provided R1's medication list. LALD/RN-A then placed a phone call to a Residex representative to access R1's June MAR as requested. LALD/RN-A stated the representative was unable to produce the MAR as requested due to the resident being discharged. LALD/RN-A stated, "This is all I can give you." The surveyor was unable to review R1's MAR for content and documentation. Additionally, the Residex representative reviewed R1's record for a medication and treatment plan.	0 720		

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0 720	Continued From page 14 She explained when the services were selected for R1 within the assessment, some of the information to develop the medication and treatment plan was not "checked", thus no clear medication or treatment plan was created by the licensee. LALD/CNS-A stated he likely missed checking the proper boxes to create the plans. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 720		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services;	0 730		

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0 730	Continued From page 15 (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure documentation of content in the resident's record as required 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 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).	0 730		

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0 730	Continued From page 16 The findings include: R1's Service Plan dated January 26, 2023, indicated he received the services of medication management, blood sugar monitoring, behavior management, respiratory equipment assistance, bathing reminders and laundry. On October 30, 2023, at 12:05 p.m. unlicensed personnel (ULP)-C stated when he worked with R1, he assisted with blood sugar checks, medication administration, behavior interventions, transportation to various locations of R1's choosing, and reminders for showering. R1's Service Recap Summary for R-tasks (within Residex-the licensee's electronic medical record system) dated June 1, 2023, through June 30, 2023, indicated the services/ tasks the licensee's ULP completed/documented. The tasks/services included: -medication administration (7:00 a.m., 8:00 a.m., 9:00 a.m., 12:00 p.m., 5:00 p.m., 8:00 p.m., and 11:00 p.m.) -record blood glucose (blood sugar reading) (7:00 a.m., 12:00 p.m., 9:00 p.m.) -manage behavior-agitation -manage behavior-anxiety -grooming -bathing reminder -housekeeping -laundry -manage behavior-property destruction -manage behavior-repetitive behavior -remove garbage -shopping assistance -put away laundry -respiratory equipment care -laundry pick up	0 730		

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0 730	Continued From page 17 R1's Service Recap Summary lacked documentation of any services/tasks completed on June 3, 2023, June 10, 2023, June 11, 2023, June 17-20, 2023, and June 24-30, 2023. Additionally, the Service Recap Summary lacked consistent documentation of services/tasks completed on June 1, 2023, June 2, 2023, June 4-9, 2023, June 12-16, 2023, June 21, 2023, and June 23, 2023. On October 31, 2023, at 12:30 p.m. licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A reviewed the above information and stated, "No, the services were not documented by the staff." The licensee's Resident Record and Documentation policy dated August 1, 2021, indicated staff providing assisted living services will document, daily, medications, services, treatments, or therapies provided to resident. When medications, services, treatments, or therapies or not performed per the service agreement and schedule, staff must document the reason why it was not performed or administered. Tasks not performed or administered must be reported and followed up on to meet the resident's needs. No further information provided. TIME PERIOD FOR CORRECTIONS: Twenty-one (21) days	0 730		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire	0 790		

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0 790	Continued From page 18 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 maintain the portable fire extinguishers. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On October 30, 2023, from 1:30 p.m. to 2:30 p.m., survey staff toured the facility with the the owner (O)-B and unlicensed personnel (ULP-C). During the tour, survey staff observed that both portable fire extinguishers in the facility lacked a current tag or any documentation showing the required annual service date, and also lacked any tag or documentation showing the required monthly visual inspections to date. O-B visually verified this deficient finding at the time of discovery.	0 790		

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0 790	Continued From page 19 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 790		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system	0 810		

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0 810	Continued From page 20 activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on a record review and interview, the licensee failed to develop a fire safety and evacuation plan with the required elements, failed to provide required employee and resident training on fire safety and evacuation, and failed to conduct required evacuation drills. This had the potential 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 November 2, 2023, with the owner (O)-B on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of the available documentation indicated that the licensee did not have employee actions to be taken in the event of a fire or similar emergency. The facility plan indicated to use RACE acronym but was very vague and did not provide complete actions for employees to take in the event of a fire or similar emergency. During interview, O-B verified that the fire safety and	0 810		

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0 810	Continued From page 21 evacuation plan for the facility lacked these provisions. Record review of the available documentation indicated that the licensee did not have fire protection procedures necessary for residents included in the fire safety and evacuation plan. During interview, O-B verified that the fire safety and evacuation plan for the facility lacked these provisions. Record review of the available documentation indicated that the fire safety and evacuation plan did not include procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. The facility plan did include some provisions for the relocation of residents but did not specify how to move or evacuate residents or identify the unique and unusual needs of the residents. During interview, O-B verified that the fire safety and evacuation plan for the facility lacked these provisions. Record review of available documentation indicated that the licensee did not provide employee training on the fire safety and evacuation plan twice per year after the training at initial hire. During interview, O-B stated the licensee did not have documentation on employee training on the fire safety and evacuation plan. Record review of the available documentation indicated that the licensee did not provide annual training to residents who can assist in their own evacuation on the proper actions to take in the event of a fire including movement, evacuation, or relocation as required by statute. During	0 810		

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0 810	Continued From page 22 interview, O-B stated that the facility did not have documentation on offering resident training on the fire safety and evacuation plan. Record review of the available documentation indicated that the licensee did not conduct evacuation drills twice per year per shift and every other month as required by statute. Provided documentation was meeting minutes from meetings held on the first and second shifts on January 2, 2023 and April 3, 2023. No further documentation of evacuation drills was provided. During interview, O-B verified this deficient condition. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident for one of one resident (R1).	0 970		

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0 970	Continued From page 23 This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 was admitted to the assisted living on January 25, 2023, and had an assisted living contract dated January 25, 2023. R1's assisted living contract included a clause that indicated the resident would waive the facility's liability for health, safety, or personal property of a resident. The facility's contract page ten contained the following: 24. PROVISIONS RELATED TO LIABILITY Damage of Injury to Resident of Resident's Property. We are not responsible for any damage or injury suffered by you, your property, your guests, or their property that was not caused by us. We strongly recommend that Resident obtain renter's insurance at an appropriate level to insure against loss of Resident's personal property, as well as related incidental and consequential damages, or such other or additional insurance as Resident considers necessary to protect against injuries and property damage. Our insurance may not cover the loss of your personal property and the incidental and consequential damages arising from the loss of such property. Your personal property includes but is not limited to dentures, glasses, and hearing aids. On October 31, 2023, licensed assisted living	0 970		

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0 970	Continued From page 24 director/clinical nurse supervisor (LALD/CNS)-A stated the licensee was not aware of this regulation with the contract and all previous assisted living contracts would include the same language. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01370 SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a	01370		

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01370	Continued From page 25 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 interview and record review, the licensee failed to ensure training and competency evaluations for the required topics were completed by one of one unlicensed personnel (ULP-C) prior to providing direct cares. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-C had a hire date of September 1, 2021, and provided direct care services under the licensee's assisted living license. On October 30, 2023, at 12:05 p.m. ULP-C stated he had provided medication administration, blood	01370		

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01370	Continued From page 26 sugar checks and assisted R1 with behavior management strategies. ULP-C's record lacked evidence of training prior to providing services for the following: -documentation requirements for all services provided; -medication, exercise, and treatment reminders; and -awareness of commonly used health technology equipment and assistive devices On October 31, 2023, at 2:45 p.m. licensed assisted living director/clinical nurse supervisor (LALD-CNS)-A stated, "What is in [ULP-C's] file is what we have, I assign what the staff are to take and expect them to complete it." The licensee's Competency Training Evaluation policy dated August 1, 2021, indicated when a registered nurse or licensed health professional staff of [licensee name] delegates tasks, prior to the delegation of services they must make certain the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each client and are able to demonstrate the ability to competently follow the procedures and perform the tasks. Training and competency evaluations would include: -documentation requirements for all services provided; -medication, exercise, and treatment reminders; and -awareness of commonly used health technology equipment and assistive devices No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		

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LEGEND HEALTH CARE RESOURCES	2240 IDLE COURT MAPLEWOOD, MN 55109

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01380 SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure competency training and evaluations were completed by one of one unlicensed personnel (ULP-C) prior to providing direct cares. 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:	01380		

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01380	Continued From page 28 ULP-C had a hire date of September 1, 2021, and provided direct care services under the licensee's assisted living license. On October 30, 2023, at 12:05 p.m. ULP-C stated he had provided medication administration, blood sugar checks and assisted R1 with behavior management strategies. ULP-C's training record lacked the following required training and competency topic prior to providing services: -Range of motion and positioning On October 31, 2023, at 2:45 p.m. licensed assisted living director/clinical nurse supervisor (LALD-CNS)-A stated, "What is in [ULP-C's] file is what we have, I assign what the staff are to take and expect them to complete it." The licensee's Competency Training Evaluations policy dated August 1, 2021, indicated when a registered nurse or licensed health professional staff of [licensee name] delegates tasks, prior to the delegation of services they must make certain the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each client and a re able to demonstrate the ability to competently follow the procedures and perform the tasks. The competency training must include the following: -Range of motion and positioning No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		

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01440	Continued From page 29	01440		
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure direct supervision of one of one unlicensed personnel (ULP-C) performing delegated tasks was provided within 30 calendar days after the date on which the individuals began working for the licensee. 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	01440		

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01440	Continued From page 30 cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-C ULP-C was hired September 1, 2021, to provide direct care services to the residents at the assisted living facility. On October 30, 2023, at 12:05 p.m. ULP-C stated he had provided medication administration, blood sugar checks and assisted R1 with behavior management strategies. ULP-G's employee record did not include a 30-day direct supervisory review. On October 31, 2023, at 2:45 p.m. licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated he did not see a 30 day direct supervisory review in ULP-C's record, but would look at the main office. The licensee's Supervision of Staff-Delegated Services policy dated August 1, 2023, indicated direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for [licensee name] and first performs the delegated tasks for residents and thereafter as needed based on performance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		

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01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this	01500		

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01500	Continued From page 32 subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment for one of one employee (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-C was hired on September 1, 2021, to provide direct care services to the licensee's	01500		

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01500	Continued From page 33 residents. On October 30, 2023, at 12:05 p.m. ULP-C stated he had provided medication administration, blood sugar checks and assisted R1 with behavior management strategies. ULP-C's record included 8.5 hours of annual training for 2022 and 2023; however, the record lacked the required annual training content to include: -Reporting maltreatment of vulnerable adults; -Effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; and -Principles of person-centered planning/service delivery On October 31, 2023, at 2:45 p.m. licensed assisted living director/clinical nurse supervisor (LALD-CNS)-A stated, "What is in [ULP-C's] file is what we have." The licensee's Annual Required Staff Training policy dated August 1, 2021, indicated all staff that perform direct care services at [licensee name] will complete at least eight hours of annual training for each 12 months of employment. The following training elements MUST be included every 12 months to all staff who performs direct care services: -Reporting maltreatment of vulnerable adults or minors; -Effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; and	01500		

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01500	Continued From page 34 -Principles of person-centered planning/service delivery No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		
01530 SS=D	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced	01530		

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01530	Continued From page 35 by: Based on interview and record review, the licensee failed to ensure one of one employee (unlicensed personnel (ULP)-C) received the required amount of dementia care training in the required time frame. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The licensee provided services under an Assisted Living license. ULP-C had a hire date of September 1, 2021, and provided direct care services under the licensee's assisted living license. INITIAL TRAINING ULP-C's employee record contained evidence of Educare training (the licensee's online training system) with a topic named Dementia-A Refresher. The Dementia Training Refresher dated September 20, 2021, indicated one hour of training and not the required eight hours of training within 160 working hours of the employment start date as required. Furthermore, ULP-C's record lacked the required dementia related training topics to include: -an explanation of Alzheimer's disease and other dementias; - assistance with activities of daily living;	01530		

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01530	Continued From page 36 - problem solving with challenging behaviors; - communication skills; and - person centered planning and service delivery ANNUAL TRAINING ULP-C's record included Educare training named Dementia-A Refresher dated September 30, 2022, and October 15, 2023, and each indicated one hour of training time. ULP-C's record lacked the required two hours of annual dementia training. On October 31, 2023, at 2:30 p.m. licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated, "Whatever the Educare transcript shows is what was taken for the dementia related training." The licensee's Dementia Training policy dated August 1, 2021, indicated direct care employees will complete eight hours of initial training within 160 hours of the employment start date and would include the required topics of: - an explanation of Alzheimer's disease and other dementias; - assistance with activities of daily living; - problem solving with challenging behaviors; - communication skills; and - person centered planning and service delivery Additionally, the policy indicated the staff would complete two hours of annual dementia training. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01530		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring	01620		

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01620	Continued From page 37 (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed a timely 14-day assessment, an assessment for a change in condition following hospitalizations and a reassessment not to exceed 90 days 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	01620		

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01620	Continued From page 38 was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 began receiving services under the licensee's assisted living license on January 25, 2023. R1's diagnoses included type two diabetes (when the pancreas cannot effectively manage blood sugar), bipolar disorder (a mental disorder characterized by periods of depression and periods of abnormally elevated mood that each last from days to weeks), and schizophrenia (a severe brain disorder that affects how people perceive and interact with reality, often causing hallucinations, delusions, and social withdrawal), and anxiety. R1' Service Plan dated January 26, 2023, indicated he received services to include medication management, blood sugar checks, and behavior management. R1's clinical notes included the following entries: -dated March 27, 2023, entered by licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A-"[R1] left the home about 3:00 p.m. on Sunday to see his friends at [restaurant name] in Saint Paul and he never came back to home until now. At 9:30 this morning we got from [hospital name] ER (emergency room) staffer and reported that [R1] is at the [hospital name] ER with manic and mental health crisis. The ER attending physician told me he ordered some psychiatrics [sic] consultation and waiting their report. Currently we are still waiting updates from the hospital." No further notes regarding R1's	01620		

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01620	Continued From page 39 hospital discharge appeared to be written and no hospital discharge or after visit summary was provided. -dated April 13, 2023, entered by unlicensed personnel (ULP)-C-"R1 came home last night after being released from the hospital, he was very loud and very aggressive. The day staff was informed that he would be put on a 72-hour hold." No follow up notes were written by LALD/CNS-A. No discharge summary provided. -dated May 11, 2023, by ULP-C-"[R1] was put on a 72 hour hold at [hospital name] on May 9, 2023, at 2:46 p.m., he was admitted for his bi-polar mania and agitation. He arrived at home this morning at around 11:00 a.m." -dated June 22, 2023, by LALD/CNS-A-" resident is on the bed sleeping, weekly assessment completed, the resident complains of bilateral lower leg pain, uses Diclofenac Sodium Topical Gel, and PRN [as needed] Tylenol but stated they don't help that much. Current VSS [vital signs stable], blood glucose [blood sugar] averages 230, HHA [home health aide/ULP] checks blood glucose 4 [four] times daily. Primary provider appointment done on June 14, 2023, for diabetes management follow up with no new orders. he had his psychiatrist appoint on June 5, 2023, and follow up appointment is scheduled on June 27, 2023. Overall, the resident is doing better these days no more manic behaviors. sleeps more than usual. He goes outside as usual with his Ford truck. He likes to eat outside most of the time. No outside incidents reported these weeks. Will continue to monitor." LALD/RN-A did not use the uniform assessment tool to document this "assessment". -dated August 1, 2023, within R1's discharge note, LALD/CNS-A entered "On July 21 and 28, he [R1] was admitted to [hospital name] ER for hyperglycemia and manic behaviors."	01620		

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01620	Continued From page 40 R1's record included two hospital discharge/after visit summaries (AVS) for a hospitalization dated May 6, 2023, through May 8, 2023, and an ER visit on July 21, 2023. R1's comprehensive assessments since admission were requested. On October 31, 2023, at 9:30 a.m. LALD/CNS-A provided the following assessments: - initial assessment was dated January 25, 2023, (day of admission), -14-day assessment dated February 16, 2023, (22 days after R1's start of services); and -April 4, 2023, labeled as clinical update assessment for behavioral updates, which indicated a mental health crisis. (Clinical note above dated March 27, 2023, indicated a hospitalization with an unknown date of discharge). The licensee failed to ensure the registered nurse (RN) completed a change in condition assessment related to R1's hospitalizations/ER visits dated March 27, 2023, April 13, 2023, May 6, 2023, and July 21, 2023. Furthermore, the licensee failed to complete R1's 14-day assessment within the required timeframe and failed to complete a reassessment not to exceed 90 days (due July 3, 2023). On October 31, 2023, at 12:50 p.m. LALD/CNS-A stated R1's 14-day assessment was late due to LALD/CNS-A having been on vacation. LALD/CNS-A stated he completed an assessment for a change in condition following R1's hospitalization dated March 27, 2023, but it was late. He stated he had not completed an assessment following R1's hospitalizations that occurred on April 13, 2023, May 6, 2023, and July	01620		

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01620	Continued From page 41 21, 2023. Additionally, LALD/CNS-A stated he was "confused about the change in condition assessments when residents were hospitalized and returned home with no medication changes and return at baseline." He stated he had not completed a timely 90-day assessment because of the resident's planned discharge within the month. The licensee's Assessments, Reviews and Monitoring policy dated August 1, 2021, indicated 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. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
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:	01650		

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01650	Continued From page 42 (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 one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R1 was admitted to the facility under the facility's Assisted Living Facility (ALF) license on January 25, 2023. R1's diagnoses included type two diabetes (when the pancreas cannot effectively manage blood	01650		

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01650	Continued From page 43 sugar), bipolar disorder (a mental disorder characterized by periods of depression and periods of abnormally elevated mood that each last from days to weeks), schizophrenia (a severe brain disorder that affects how people perceive and interact with reality, often causing hallucinations, delusions, and social withdrawal), and anxiety. R1's Service Plan dated January 26, 2023, indicated he received the services of medication management, blood sugar monitoring, behavior management, respiratory equipment assistance, bathing reminders and laundry. On October 30, 2023, at 12:05 p.m. unlicensed personnel (ULP)-C stated he had provided medication administration, blood sugar checks and assisted R1 with behavior management strategies. R1's Service Plan lacked the required content of: - the schedule and methods of monitoring staff providing services On October 31, 2023, at 11:05 a.m. licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated he was not aware the Service Plan was missing that content, would have been used for previous residents, and would work to have it amended to include the required content. The licensee's Service Plan policy dated August 1, 2021, indicated the service plan would include: -The schedule and methods of monitoring staff providing services No further information was provided.	01650		

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01650	Continued From page 44 TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01650		
01700 SS=D	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. 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 a face-to-face medication	01700		

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01700	Continued From page 45 management assessment to include all required content for one of one resident (R1) who received 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on October 30, 2023, at 12:15 p.m. licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A confirmed the licensee had provided medication management services to all the residents receiving assisted living services. R1 began receiving services under the licensee's assisted living license on January 25, 2023, and was discharged on August 1, 2023. R1's diagnoses included type two diabetes (when the pancreas cannot effectively manage blood sugar), bipolar disorder (a mental disorder characterized by periods of depression and periods of abnormally elevated mood that each last from days to weeks), schizophrenia (a severe brain disorder that affects how people perceive and interact with reality, often causing hallucinations, delusions, and social withdrawal), and anxiety. R1's Service Plan dated January 26, 2023, indicated he received the services of medication	01700		

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01700	Continued From page 46 administration and behavior management. On October 30, 2023, at 12:05 p.m. unlicensed personnel (ULP)-C stated R1 received the services of medication set up by the registered nurse and the ULP assisted with medication administration to include oral medications, an injectable insulin and an injection for bi-polar disorder. ULP-C stated R1 often refused or delayed taking his medications including his scheduled insulin. He often had high blood sugar readings and needed redirection to comply with taking his medications. On October 30, 2023, at 2:30 p.m. the surveyor requested R1's medication administration record (MAR) from June 2023, signed medication orders, assessments since admission and R1's most recent medication plan. On October 30, 2023, at 9:51 pm. LALD/CNS-A emailed the surveyor a medication list (named MAR), but not the MAR as requested. On October 31, 2023, at 12:15 p.m. the surveyor again requested R1's MAR for June 2023. LALD/CNS-A stated since R1 was discharged, he was having trouble accessing all records from Residex (the licensee's electronic medical record system). LALD/CNS-A placed a phone call to a Residex technician who assisted in review of R1's records. R1's MAR was not accessible at that time. The technician stated the assessment in Residex, when completed correctly/fully, included the required content for a medication assessment. LALD/CNS-A stated he likely had not selected all the proper content. R1's prescriber orders dated May 8, 2023, indicated he received three medications for	01700		

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01700	Continued From page 47 diabetes (injections), one for mild pain, one for muscle spasms, one for cough, three for high blood pressure, one for cholesterol, one blood thinner, two for agitation, two for anxiety, two for bi-polar disorder (one oral, one injection), two for heartburn and one supplement. R1's assessment dated April 4, 2023, in the section labeled Medication, indicated the following: - medication administration-ULP help administer medications, - needs full medication management and set up, - needs registered nurse (RN) consultation to clarify instruction from medical providers, - face to face assessment note-RN will monitor, set up and order all medications and refills, - licensed nurse is responsible for monitoring medication supplies and reordering as needed-note-yes, RN will monitor; and - self administration of medications-note-self administration of medications is not applicable. R1's record lacked evidence the RN conducted a face-to-face review of all medications R1 was known to be taking to include indications for use, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. Additionally, R1's assessment lacked the identification of interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. The licensee's Medication Assessment, Monitoring, and Reassessment policy dated	01700		

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01700	Continued From page 48 August 1, 2021, indicated: - the assessment must be conducted face-to-face with the resident by an RN. - the assessment must include an identification and review of all medications the resident is known to be taking. - the review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. - the assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700		
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 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	01730		

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01730	Continued From page 49 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 interview and record review, the licensee failed to ensure an individualized medication management plan included all required content for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	01730		

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01730	Continued From page 50 cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included type two diabetes (when the pancreas cannot effectively manage blood sugar), bipolar disorder (a mental disorder characterized by periods of depression and periods of abnormally elevated mood that each last from days to weeks), schizophrenia (a severe brain disorder that affects how people perceive and interact with reality, often causing hallucinations, delusions, and social withdrawal), and anxiety. R1's Service Plan dated January 26, 2023, indicated he received the services of medication administration and behavior management. On October 30, 2023, at 12:05 p.m. unlicensed personnel (ULP)-C stated R1 received the services of medication set up by the registered nurse and the ULP assisted with medication administration to include oral medications and injectable insulin and an injection for bi-polar. ULP-C stated R1 often refused or delayed taking his medications including his scheduled insulin. He often had high blood sugar readings and needed redirection to comply with taking his medications. On October 30, 2023, at 2:30 p.m. the surveyor requested R1's medication administration record (MAR) from June 2023, signed medication orders, assessments since admission (January 25, 2023), and R1's most recent medication plan.	01730		

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01730	Continued From page 51 On October 30, 2023, at 9:51 pm. LALD/CNS-A emailed the surveyor a medication list (named MAR), but not the MAR as requested. On October 31, 2023, at 12:15 p.m. the surveyor again requested R1's MAR for June 2023. LALD/CNS-A stated since R1 was discharged, he was having trouble accessing all records from Residex (the licensee's electronic medical record system). LALD/CNS-A placed a phone call to a Residex technician who assisted in review of R1's records. R1's MAR was not accessible at that time. The technician stated the assessment in Residex, when completed correctly/fully, included the required content for a medication assessment and medication plan. A medication plan for R1 was not found. LALD/CNS-A stated he likely had not selected the proper content. R1's prescriber orders dated May 8, 2023, indicated he received three medications for diabetes (injections), one for mild pain, one for muscle spasms, one for cough, three for high blood pressure, one for cholesterol, one blood thinner, two for agitation, two for anxiety, two for bi-polar disorder (one oral, one injection), two for heartburn and one supplement. R1's assessment dated April 4, 2023, in the section labeled Medication, indicated the following: - medication administration-ULP help administer medications, - needs full medication management and set up, - needs registered nurse (RN) consultation to clarify instruction from medical providers, - face to face assessment note-RN will monitor, set up and order all medications and refills, - licensed nurse is responsible for monitoring	01730		

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01730	Continued From page 52 medication supplies and reordering as needed-note-yes, RN will monitor; and - self administration of medications-note-self administration of medications is not applicable. R1's medication assessment/record lacked a medication plan to include the following required content: -a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; - documentation of specific resident instructions relating to the administration of medications; - identification of medication management tasks that may be delegated to unlicensed personnel; - procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and - 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. The licensee's Medication Management Individualized Plan dated August 1, 2021, indicated: [Licensee name] will develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: - a statement describing the medication management services that will be provided - a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions	01730		

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01730	Continued From page 53 - documentation of specific resident instructions relating to the administration of medications - identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis - identification of medication management tasks that may be delegated to unlicensed personnel. - procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services, and - 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. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
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	01940		

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LEGEND HEALTH CARE RESOURCES	2240 IDLE COURT MAPLEWOOD, MN 55109

(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
01940	Continued From page 54 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 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 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 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on October 30, 2023, at 12:10 p.m. licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37108	A. BUILDING: _____ B. WING _____	11/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGEND HEALTH CARE RESOURCES	2240 IDLE COURT MAPLEWOOD, MN 55109

(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
01940	Continued From page 55 stated the licensee provided treatment management services to residents, including blood sugar checks and respiratory equipment such as continuous positive airway pressure (CPAP-equipment used to treat sleep apnea). R1's diagnoses included type 2 diabetes (when the pancreas no longer effectively manages insulin production to manage blood sugar levels), obstructive sleep apnea (a condition when a person obstructs their airway during sleep causing an interruption of the breathing pattern). R1's Service Plan dated January 26, 2023, indicated R1 received services to include assistance with respiratory equipment every night and blood sugar checks two times daily. On October 30, 2023, at 12:05 p.m. unlicensed personnel (ULP)-C stated when he worked with R1 he checked R1's Dexcom unit (a sensor/transmitter that provides continuous blood sugar monitoring and displays the current blood sugar level) twice daily. ULP-C added he occasionally completed a blood sugar fingerstick when the Dexcom unit was alarming high blood sugar levels but did not indicate a blood sugar number. He stated he then reported the information to LALD/CNS-A. ULP-C stated R1 was mostly independent with his CPAP machine but often refused to wear it at bedtime. He stated the staff cleaned the equipment when R1 allowed them to. ULP-C stated the staff's role was just to document R1's use of the CPAP equipment. On October 30, 2023, at 2:30 p.m. the surveyor requested R1's records to include R1's treatment plan, medication administration record (MAR) and treatment administration record (TAR) for June 2023.	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37108	A. BUILDING: _____ B. WING _____	11/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGEND HEALTH CARE RESOURCES	2240 IDLE COURT MAPLEWOOD, MN 55109

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01940	Continued From page 56 On October 30, 2023, at 9:51 p.m. LALD/CNS-A sent an email to the surveyor that included a medication list (not a medication administration record or treatment administration record as requested). On October 31, 2023, at 11:45 a.m. LALD/CNS-A provided the surveyor with R1's Service Recap Summary (known as the task documentation record) dated June 2023. The task documentation record included the tasks "record blood glucose (blood sugar)" and "respiratory equipment care". The task documentation record lacked specific direction/instructions related to the use of the Dexcom unit, blood sugar checks and the CPAP machine. On October 31, 2023, at 12:15 p.m. the surveyor again requested R1's Treatment Record. LALD/CNS-A stated since R1 was discharged, he was having trouble accessing all records from Residex (the licensee's electronic medical record system). LALD/CNS-A placed a phone call to a Residex technician who assisted in review of R1's records. The technician stated there was no indicated check mark within R1's Service Plan or assessment to indicate the services of "respiratory equipment" and "blood sugar checks" were "supervision services", and explained when the services are properly checked as a supervision service, the system then auto populated the selections needed to develop a treatment plan. LALD/RN-A stated he did not realize this and had not properly selected the required boxes. LALD/CNS-A stated within "R-Tasks" (the task set up area within Residex) there was more description with the tasks assigned for the ULP. LALD/CNS-A was unable to further provide this information.	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37108	A. BUILDING: _____ B. WING _____	11/02/2023

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01940	Continued From page 57 R1's record lacked a treatment plan for the services of CPAP and blood sugar checks (with both Dexcom unit use and fingerstick blood sugar checks) and lacked the required content of a treatment plan to include: (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 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. The licensee's Treatment and Therapy Management Plan policy dated August 1, 2021, indicated: [Licensee name] will develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: a. A statement of the type of services that will be provided. b. Documentation of specific resident instructions relating to the treatments or therapy administration c. Identification of treatment or therapy tasks that will be delegated to unlicensed personnel.	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01940	Continued From page 58 d. Procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services. e. Any resident-specific requirements relating to documentation of treatment and therapy received. f. Verification that all treatment and therapy was administered as prescribed. g. 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. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		

Minnesota Department of Health

625 Robert St N
St. Paul
55155

Type: Full
Date: *10/30/23*
Time: 13:00:00
Report: 1043231092

Food and Beverage Establishment Inspection Report

Location:

Legend Health Care Resources
2240 Idle Court
Maplewood, MN55109
Ramsey County, 62

Establishment Info:

ID #: 0039127
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6513300405
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

Inspection was completed with Ahmed Anshur. Deb Jacobson was the lead Health Regulation Division Nurse Evaluator on site completing the site survey.

Facility currently has zero residents since June, 2023. Facility has a maximum of five residents.

This facility has a residential kitchen with residential equipment. The kitchen finishes and surfaces are well maintained.

Food service will be inspected during the next survey.

Type: Full
Date: *10/30/23*
Time: 13:00:00
Report: 1043231092
Legend Health Care Resources

Food and Beverage Establishment Inspection Report

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 1043231092 of 10/30/23.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Inspection report reviewed with person in charge and emailed.

Signed:_____
Ahmed Anshur
Owner

Signed:_____
Blia Lor
Public Health Sanitarian I
OLF
651-231-7981
blia.lor@state.mn.us