Electronically Delivered

October 18, 2024

Licensee
Morning Glory Homes Inc.
18626 Clearview Drive
Minnetonka, MN  55345

RE: Project Number(s) SL29504015

Dear Licensee:

On September 26, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the July 5, 2024, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: jess.schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

JMD

Electronically Delivered

August 2, 2024

Licensee
Morning Glory Homes Inc
18626 Clearview Drive
Minnetonka, MN 55345

RE: Project Number(s) SL29504015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 5, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

**STATE CORRECTION ORDERS**

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

**IMPOSITION OF FINES**

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

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

In accordance with Minn. Stat. § 144G.31, Subd. 4(a)(5), MDH may impose fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. MDH may impose a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. MDH also may impose a

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

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

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

**St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00**
**St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - $3,000.00**
**St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $3,000.00**

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $6,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

**REQUESTING A HEARING**
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this

section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. to submit a hearing request, please visit:
**https://forms.web.health.state.mn.us/form/HRDAppealsForm**

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

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

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

If you have any questions, please contact me.

Sincerely,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: Jess.Schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

HHH

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 29504 | A. BUILDING: _____ B. WING _____ | 07/05/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MORNING GLORY HOMES INC | 18626 CLEARVIEW DRIVE MINNETONKA, MN 55345 |

| (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 |
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| 0 000 | Initial Comments<br><br>******ATTENTION******<br><br>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.<br><br>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.<br><br>INITIAL COMMENTS:<br><br>SL29504015-0<br><br>On July 1, 2024, through, July 5, 2024, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 6 residents receiving services under the provider's Assisted Living Facility license.<br><br>An immediate correction order was identified on July 1, 2024, issued for SL29504015-0, tag identification 2310.<br><br>An immediate correction order was identified on July 2, 2024, issued for SL29504015-0, tag identification 0820.<br><br>An immediate correction order was identified on July 2, 2024, issued for SL29504015-0, tag identification 1290. | 0 000 | Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction.<br><br>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.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3. | |

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| 0 000 | Continued From page 1<br><br>On July 3, 2024, the immediacy of correction order 2310 was removed, however non-compliance remained at an scope and level of I.<br><br>On July 3, 2024, the immediacy of correction order 1290 was removed, however non-compliance remained at an scope and level of I.<br><br>On July 7, 2024, the immediacy of correction order 0820 was removed, however non-compliance remained at an scope and level of G. | 0 000 | | |
| 0 120 SS=C | 144G.11 APPLICABILITY OF OTHER LAWS<br><br>Assisted living facilities:<br>(1) are subject to and must comply with chapter 504B;<br>(2) must comply with section 325F.72; and<br>(3) are not required to obtain a lodging license under chapter 157 and related rules.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure the assisted living facility website and marketing information did not advertise the facility provided specialty in dementia care. This had the potential to affect all current and prospective residents.<br><br>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 | 0 120 | | |

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| 0 120 | Continued From page 2<br>or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>The facility was licensed as an assisted living facility with an effective date of January 1, 2024, and an expiration date December 31, 2024.<br><br>On July 1, 2024, at 10:20 a.m., during the entrance conference, licensed assisted living director (LALD)-C confirmed knowledge of assisted living rules and regulations.<br><br>On July 3, 2024, at 2:19 p.m., the licensee's website was reviewed with LALD-C and the surveyor observed it advertised "Memory care and assisted living in a residential setting" in its heading. Under, Types of Clients We Care For, the website listed Dementia (all levels) and Alzheimer's disease.<br><br>On July 3, 2024, at 2:19 p.m., LALD-C stated they had not looked at the licensee's website for years and indicated the website was not correct and they would correct the dementia advertising on the website.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 120 | | |
| 0 480 SS=F | 144G.41 Subd 1 (13) (i) (B) Minimum requirements<br><br>(13) offer to provide or make available at least the following services to residents: | 0 480 | | |

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| 0 480 | Continued From page 3<br>(B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code.<br><br>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).<br><br>The findings include:<br><br>Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated July 2,2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.<br><br>TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates. | 0 480 | | |
| 0 490 SS=F | 144G.41 Subd 1 (13) (ii)-(vii) Minimum requirements<br><br>(iv) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, | 0 490 | | |

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| 0 490 | Continued From page 4<br><br>and provide the name of or other identifying information about the persons responsible for providing this assistance;<br>(v) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance;<br>(vi) provide culturally sensitive programs; and<br>(vii) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large; and<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to have daily programs of social and recreational activities based on individual and group interests, physical, mental, and psychosocial needs, that created opportunities for active participation in the community at large. This had the potential to affect all residents of the facility.<br><br>This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client'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 clients).<br><br>The findings include: | 0 490 | | |

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| 0 490 | Continued From page 5<br><br>On July 1, 2024, at 11:40 a.m., during a tour of the facility, the surveyor observed the licensee had no posted daily program of social and recreational activities.<br><br>On July 1, 2024, at 10:40 a.m., licensed assisted living director (LALD)-C indicated the licensee did not have daily activities since the residents had refused all activities last year, but a social worker would come to the facility once a week for activities. LALD-C also indicated daily activities had been part of their quality management and they were in the process of trying to get different activities planned after they did a recent survey with residents.<br><br>The licensee's 1.34 Activity Programming policy dated August 21, 2021, indicated licensee would create a monthly activity calendar and provide the calendar to all residents.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 490 | | |
| 0 510 SS=F | 144G.41 Subd. 3 Infection control program<br><br>(a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control.<br>(b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. | 0 510 | | |

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| 0 510 | Continued From page 6<br><br>(c) The facility must maintain written evidence of compliance with this subdivision.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program to comply with accepted health care, medical, and nursing standards for infection control related to gloving and hand hygiene. The deficient practice had the potential to affect residents, employees, and visitors.<br><br>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).<br><br>The findings include:<br><br>On July 2, 2024, at 7:56 a.m., the surveyor observed unlicensed personnel (ULP)-E assist R2 with getting medications set up by the nurse. During the observation, ULP-E did not perform hand hygiene prior to the task. ULP-E had donned (applied) gloves prior to the task but did not performing hand hygiene. After the task was completed, ULP-E doffed (removed) the gloves but did not perform hand hygiene.<br><br>On July 2, 2024, at 8:05 a.m., the surveyor observed ULP-E prepare R3's medication. During the observation, ULP-E did not perform hand hygiene prior to the task. ULP-E had | 0 510 | | |

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| 0 510 | Continued From page 7<br><br>donned gloves prior to the task but did not performing hand hygiene. Also, at 8:16 a.m., the surveyor observed ULP-E administer R3's Systane (moisturizing) eye drops without completion of hand hygiene prior to the task and did not change their gloves before the procedure. After both tasks were completed, ULP-E doffed the gloves but did not perform hand hygiene.<br><br>On July 2, 2024, at 8:19 a.m., the surveyor observed ULP-E prepare R1's medication. During the observation, ULP-E did not perform hand hygiene prior to the task. ULP-E had donned gloves prior to the task but did not performing hand hygiene. After the task was completed, ULP-E doffed the gloves but did not perform hand hygiene.<br><br>On July 2, 2024, at 8:23 a.m., the surveyor observed ULP-E prepare R4's medication. During the observation, ULP-E did not perform hand hygiene prior to the task. ULP-E had donned gloves prior to the task but did not performing hand hygiene. After the task was completed, ULP-E doffed the gloves but did not perform hand hygiene.<br><br>On July 2, 2024, at 8:30 a.m., the surveyor observed ULP-E prepare R5's medication. During the observation, ULP-E did not perform hand hygiene prior to the task. ULP-E had donned gloves prior to the task but did not performing hand hygiene. After the task was completed, ULP-E doffed the gloves but did not perform hand hygiene. Also, the surveyor observed ULP-E getting a clean glass from the dishwasher to prepare powdered medication in water while wearing gloves.<br><br>On July 2, 2024, at 8:37 a.m., the surveyor | 0 510 | | |

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| 0 510 | Continued From page 8<br><br>observed ULP-E prepare R6's medication. During the observation, ULP-E did not perform hand hygiene prior to the task. ULP-E had donned gloves prior to the task but did not performing hand hygiene. After the task was completed, ULP-E doffed the gloves but did not perform hand hygiene.<br><br>On July 5, 2024, at 3:03 p.m., clinical nurse supervisor (CNS)-B indicated all staff have been trained and were expected to complete hand hygiene before donning and after doffing gloves and between resident cares.<br><br>The licensee's 8.07 Gloves policy dated July 28, 2021, indicated hands are to be washed (hand hygiene) prior to donning and after doffing gloves each time.<br><br>The licensee's 8.09 Hand Washing policy dated July 28, 2021, indicated hand washing would be performed between tasks and procedures.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 510 | | |
| 0 630 SS=E | 144G.42 Subd. 6 (b) Compliance with requirements for reporting ma<br><br>(b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be | 0 630 | | |

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| 0 630 | Continued From page 9<br><br>taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for two of two residents (R1, R2).<br><br>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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).<br><br>The findings include:<br><br>R1<br>R1 was admitted on September 9, 2021, with diagnoses of Korsakoff's syndrome (memory disorder) and cerebral infarction due to unspecified occlusion or stenosis right middle cerebral artery (stroke).<br><br>R1's Service Plan dated September 9, 2021, indicated R1 received services including medication administration and nail care.<br><br>On July 2, 2024, at 8:19 a.m., the surveyor observed unlicensed personnel (ULP)-E prepare and administer medications to R1. | 0 630 | | |

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| 0 630 | Continued From page 10<br><br>R1's IAPP completed on July 1, 2024, identified R1 was at risk to be abused and at risk to abuse other vulnerable adults. R1's IAPP lacked statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults.<br><br>R2<br>R2 was admitted on September 5, 2023, with diagnoses of myalgic encephalomyelitis (chronic fatigue syndrome), postural orthostatic tachycardia syndrome (heart rate increases on changing posture), fibromyalgia (widespread pain), and chronic migraine headache.<br><br>R2's Service Plan created on September 6, 2023, signed on September 16, 2023, indicated R2 received services including medication administration, assistance with activities of daily living (dressing, grooming, bathing), housekeeping, nail care, meal assistance, and safety checks.<br><br>On July 2, 2024, at 7:56 a.m., the surveyor observed ULP-E prepare and administer medications to R2.<br><br>R2's IAPP completed on June 12, 2024, lacked assessment of the person's risk of abusing other vulnerable adults.<br><br>On July 5, 2024, at 3:15 p.m., clinical nurse supervisor (CNS)-B stated all the IAPP assessment questions were built into their electronic records program and the registered nurse performing the assessment was to complete all the questions.<br><br>On July 5, 2024, at 3:16 p.m., licensed assisted living director (LALD)-C stated the licensee relied | 0 630 | | |

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| 0 630 | Continued From page 11<br><br>on their electronic records program to prompt the nurse to input the required information and indicated this must have been an oversight.<br><br>The licensee's 6.05 Individualized Abuse Prevention Plan policy dated August 1, 2021, indicated all residents would have an IAPP addressing the person's susceptibility to abuse, the person's risk of abusing other vulnerable adults, and specific measures would be taken to minimize the risk of abuse to that person and other vulnerable adults.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 630 | | |
| 0 660 SS=F | 144G.42 Subd. 9 Tuberculosis prevention and control<br><br>(a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines.<br>(b) The facility must maintain written evidence of compliance with this subdivision.<br><br>This MN Requirement is not met as evidenced | 0 660 | | |

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| 0 660 | Continued From page 12<br><br>by:<br>Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included baseline history and symptom screen for two of two employees (unlicensed personnel (ULP)-A, ULP-E).<br><br>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).<br><br>The findings include:<br><br>ULP-A<br>ULP-A was hired on December 28, 2023.<br><br>ULP-A's personnel record had a blank form for Baseline TB Screening Tool for HCWs (health care workers) that included a screening for TB history and symptom screening. The record lacked TB history and Symptom screening.<br><br>ULP-E<br>ULP-E was hired on November 4, 2023.<br><br>ULP-E's personnel record had a blank form for Baseline TB Screening Tool for HCWs that included a screening for TB history and symptom screening. The record lacked TB history and Symptom screening.<br><br>On July 5, 2024, at 2:45 p.m., clinical nurse | 0 660 | | |

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| 0 660 | Continued From page 13<br><br>supervisor (CNS)-B stated the licensee's process would be to perform the TB history and symptom screen on all new hires and if the new hire had no signs or symptoms of TB then the new hire would go to the clinic for TB blood test.<br><br>On July 5, 2024, at 2:46 p.m., licensed assisted living director (LALD)-C acknowledged ULP-A and ULP-E did not have the Baseline TB Screening Tool for HCWs completed. LALD-C indicated the procedure for ensuring this was completed was for LALD-C to print a blank Baseline TB Screening Tool for HCWs form at hire and place it in the personnel file for the nurse to complete but their nurse had to follow the new hire check list.<br><br>The licensee's 8.16 Tuberculosis Screening policy dated July 28, 2021, indicated new staff would be screened for active signs of TB using the Baseline TB Screening Tool for HCWs.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 660 | | |
| 0 680 SS=F | 144G.42 Subd. 10 Disaster planning and emergency preparedness<br><br>(a) The facility must meet the following requirements:<br>(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;<br>(2) post an emergency disaster plan prominently; | 0 680 | | |

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| 0 680 | Continued From page 14<br><br>(3) provide building emergency exit diagrams to all residents;<br>(4) post emergency exit diagrams on each floor; and<br>(5) have a written policy and procedure regarding missing residents.<br>(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.<br>(c) The facility must meet any additional requirements adopted in rule.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to develop and publicly post a written emergency disaster plan (EDP) with all the required content. This had the potential to affect all residents, employees, and visitors to the facility.<br><br>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).<br><br>The findings include:<br><br>On July 1, 2024, at 11:40 a.m., during a tour of the facility, the surveyor did not observe an EDP was posted prominently. | 0 680 | | |

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| 0 680 | Continued From page 15<br><br>On July 2, 2024, at 9:14 a.m., licensed assisted living director (LALD)-C informed the surveyor upon requesting the EDP, it was not available as the licensee was in the process of working on the plan.<br><br>On July 3, 2024, at 1:29 p.m., LALD-C provided the EDP and stated the Emergency Preparedness Plan was inadequate as this has been in the works. Also, LALD-C stated they have not had any emergency drills or tabletop drills for the facility.<br><br>The licensee's undated EDP lacked the following content:<br>- Process for emergency plan collaboration;<br>- Development of emergency plan policies and procedures;<br>- Subsistence Needs for Staff and Patients;<br>- Procedure for Tracking of Staff and Patients;<br>- Policies and Procedures including Evacuation;<br>- Policies and Procedures for Medical Documents;<br>- Policies and Procedures for Volunteers;<br>- Arrangement with Other Facilities;<br>- Emergency Officials Contact Information;<br>- Sharing Information on Occupancy/Needs;<br>- Long Term Care (LTC) Family Notifications;<br>- Emergency Prep Training and Testing;<br>- Emergency Prep Training Program; and<br>- Emergency Prep Testing Requirements.<br><br>The licensee's 9.01 Emergency Preparedness Plan - Appendix Z Compliance policy dated August 1, 2021, indicated the licensee would have an effective and compliant Emergency Preparedness Plan and the plan would be aligned with the Centers for Medicare and Medicaid Services State Operations Manual Appendix Z: | 0 680 | | |

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| 0 680 | Continued From page 16<br>"Emergency Preparedness for All Providers and Supplier Types: Interpretive Guidance."<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 680 | | |
| 0 810 SS=F | 144G.45 Subd. 2 (b)-(f) Fire protection and physical environment<br><br>(b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:<br>(1) location and number of resident sleeping rooms;<br>(2) employee actions to be taken in the event of a fire or similar emergency;<br>(3) fire protection procedures necessary for residents; and<br>(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.<br>(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.<br>(d) Fire safety and evacuation plans shall be readily available at all times within the facility.<br>(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.<br>(f) Evacuation drills are required for employees twice per year per shift with at least one | 0 810 | | |

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| 0 810 | Continued From page 17<br><br>evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to develop a fire safety and evacuation plan with the required elements and failed to conduct required evacuation drills as required. This had the potential to directly affect all residents, staff, and visitors.<br><br>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).<br><br>The findings include:<br><br>On July 2, 2024, at 11:00 a.m., licensed assisted living director (LALD)-C provided documentation on the fire safety and evacuation plan (FSEP), fire safety and evacuation training for the facility, and fire safety and evacuation drills for the facility.<br><br>FIRE SAFETY AND EVACUATION PLAN<br>The posted emergency evacuation plan did not show the location and number of resident rooms.<br><br>The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or | 0 810 | | |

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| 0 810 | Continued From page 18<br><br>similar emergency relative to the facility's building layout and environmental risks. The FSEP was provided by a third-party consultant, and it was not updated to meet the facility-specific layout. The FSEP included the RACE (Remove, Alarm, Confine and Extinguish or Evacuate) acronym as the fire safety procedure and instructed staff to pull the nearest fire alarm and close fire doors in case of fire, but the facility did not have a fire alarm system or fire doors.<br><br>The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan failed to include ways to move, evacuate residents based on the facility's specific layout in the event of a fire or similar emergency.<br><br>During the interview on July 2, 2024, at 11:00 a.m., LALD-C stated the facility needed to update the fire safety and evacuation plan, including the facility-specific fire safety protocols.<br><br>DRILLS<br>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 indicated that the drill was conducted in July 2023, November 2023, and 6/20/2024, with no further drills being documented.<br><br>During the interview on July 2, at 11:00 a.m., LALD-C confirmed that the drills were conducted only twice in 2023 and once in 2024. LALD-C verified that there were no further documented | 0 810 | | |

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| 0 810 | Continued From page 19<br>drills for the facility and verified this deficient condition.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 810 | | |
| 0 820 SS=G | 144G.45 Subd. 2 (g) Fire protection and physical environment<br><br>(g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide a resident bedroom with the minimum window opening meeting the minimum state standard for egress. This affected the occupied resident in bedroom #1 on the lower level.<br><br>This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to | 0 820 | This immediate correction order identified on July 2, 2024, has had the immediacy lifted as of July 7, 2024, however non-compliance remained a scope and level of G. | |

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| 0 820 | Continued From page 20<br><br>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).<br><br>The findings include:<br><br>On July 2, 2024, at 10:00 a.m., survey staff toured the facility with the licensed assisted living director (LALD)-C. During the facility tour, survey staff observed the following items:<br><br>It was observed that occupied resident bedroom #1 on the lower level did not have windows that met the minimum size requirements for egress escape. The clear openable area of the opened windows measured 45 inches in height and 18 inches in width, with a total openable area of 810 square inches. The windows did not meet the minimum requirements for opening width.<br><br>Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. Survey staff explained to LALD-C that at least one egress window in each bedroom must be provided to meet the minimum state standard for an egress window to be a complying bedroom for resident occupancy. LALD-C verbally confirmed the findings.<br><br>On July 2, 2024, at 10:30 a.m., during the interview, survey staff explained to LALD-C that an immediate correction order was issued for the above finding. LALD-C acknowledged the above finding. | 0 820 | | |

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| 0 820 | Continued From page 21<br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Immediate<br><br>On July 7, 2024, the immediacy of correction order 0820 was removed, however non-compliance remained at an scope and level of G. | 0 820 | | |
| 01060 SS=F | 144G.52 Subd. 9 Emergency relocation<br><br>(a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination.<br>(b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum:<br>(1) the reason for the relocation;<br>(2) the name and contact information for the location to which the resident has been relocated and any new service provider;<br>(3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities;<br>(4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and<br>(5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal.<br>(c) The notice required under paragraph (b) must | 01060 | | |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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| 01060 | Continued From page 22<br><br>be delivered as soon as practicable to:<br>(1) the resident, legal representative, and designated representative;<br>(2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and<br>(3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days.<br>(d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation to the resident, legal representative, or designated representative and failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) when the resident did not return from the emergency relocation within four days for one of one resident (R1).<br><br>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).<br><br>The findings include:<br><br>R1 was admitted on September 9, 2021, with diagnoses of Korsakoff's syndrome (memory | 01060 | | |

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| 01060 | Continued From page 23<br><br>disorder) and cerebral infarction due to unspecified occlusion or stenosis right middle cerebral artery (stroke).<br><br>R1's Service Plan dated September 9, 2021, indicated R1 received services including medication administration and nail care.<br><br>R1's progress notes dated May 4, 2022, at 4:33 p.m., indicated R1 was sent to hospital by ambulance due to a fall and pronounced left face droop with garbled speech.<br><br>R1's progress notes dated May 24, 2022, at 2:32 p.m., indicated R1 returned to the facility by ambulance from hospital.<br><br>R1's record lacked documentation of R1, R1's legal representative, R1's designated representative, and the OOLTC received a written notice with all the required content for an emergency relocation.<br><br>On July 3, 2024, at 2:23 p.m., licensed assisted living director (LALD)-C indicated the licensee was not aware they needed to provide an emergency relocation notice or contact OOLTC when a resident was emergently relocated after four days and indicated they would review the statute.<br><br>The licensee's 1.23 Emergency Relocation policy dated August 1, 2021, indicated the licensee would provide the written emergency relocation notice when a resident had an emergency relocation.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one | 01060 | | |

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| 01060 | Continued From page 24<br>(21) days | 01060 | | |
| 01290 SS=I | 144G.60 Subdivision 1 Background studies required<br><br>(a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information.<br>(b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12.<br>(c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to ensure a background study was conducted prior to staff providing services for three of three employees (unlicensed personnel (ULP)-A, ULP-E, ULP-F) with records reviewed.<br><br>This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). | 01290 | | |

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| 01290 | Continued From page 25<br><br>The findings include:<br><br>ULP-A<br>ULP-A was hired on December 28, 2023, to provide assisted living services.<br><br>ULP-A's employee record lacked evidence of a completed background study clearance as required prior to providing services for the licensee's residents.<br><br>On July 2, 2024, at 9:41 a.m., the licensed assisted living director (LALD)-C stated they have not affiliated ULP-A to licensee's health facility identification number (HFID) when ULP-A transferred from another facility with a different license owned by the same person.<br><br>ULP-E<br>ULP-E was hired on November 4, 2023, to provide assisted living services.<br><br>On July 2, 2024, between 8:00 a.m. to 8:40 a.m., the surveyor observed ULP-E prepare and administer medications to residents (R)1, R2, R3, R4, R5, R6 without direct supervision by another staff with a cleared background study.<br><br>ULP-E's employee record lacked evidence of a completed background study clearance as required prior to providing services for the licensee's residents.<br><br>On July 2, 2024, at 9:39 a.m., the licensed assisted living director (LALD)-C stated they have been checking for her final clearance. Also, LALD-C stated they always have ULP-E work with another staff but is not directly observed during the shifts when providing direct services to | 01290 | | |

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| 01290 | Continued From page 26<br>residents.<br><br>On July 2, 2024, at 9:53 a.m., ULP-E reported getting her fingerprints done on June 28, 2024.<br><br>ULP-F<br>ULP-F was hired on July 31, 2016, to provide assisted living services.<br><br>ULP-F's employee record lacked evidence of a completed background study clearance as required prior to providing services for the licensee's residents.<br><br>On July 2, 2024, at 9:34 a.m., LALD-C stated ULP-F is working the night shifts without any direct supervision as ULP-F is the only employee staffed at night.<br><br>On July 2, 2024, at 9:47 a.m., LALD-C acknowledged the employee records lacked evidence of completed background clearance and he would correct this by driving to St. Paul to meet with someone in person to see why they have been having so many issues with the background studies; if licensee is doing things wrong, they will correct this.<br><br>The licensee's 4.02 Background Studies policy dated August 1, 2021, indicated the licensee will conduct a Minnesota Department of Human Services Background Study on all employees and no employee may provide direct services and have independent direct contact with any resident until acceptable results of the background study have been received.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: IMMEDIATE | 01290 | | |

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| 01290 | Continued From page 27<br><br>On July 3, 2024, the immediacy of correction order 1290 was removed, however non-compliance remained at an scope and level of I. | 01290 | | |
| 01530 SS=F | 144G.64 TRAINING IN DEMENTIA CARE REQUIRED<br><br>(a) All assisted living facilities must meet the following training requirements:<br>(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;<br>(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;<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the | 01530 | | |

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| 01530 | Continued From page 28<br><br>licensee failed to ensure employees received the required initial eight (8) hours of dementia care training for two of two unlicensed personnel ((ULP)-A, ULP-E).<br><br>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).<br><br>The findings include:<br><br>ULP-A<br>ULP-A was hired on December 28, 2023, to provide assisted living services.<br><br>ULP-A's student transcript dated July 2, 2024, indicated ULP-A had not completed any dementia training as registered for the courses by licensee on December 27, 2023.<br><br>ULP-E<br>ULP-E was hired on November 4, 2023, to provide assisted living services.<br><br>ULP-E's undated student transcript indicated ULP-E had not completed any dementia training as registered for the courses by licensee on November 4, 2023.<br><br>On July 3, 2024, at 2:07 p.m., licensed assisted living director (LALD)-C stated the dementia training was deficient as this was recently identified at another licensed facility owned by the same owner while being surveyed. LALD-C stated the owner had not corrected the deficiency | 01530 | | |

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| 01530 | Continued From page 29<br>at this licensee.<br><br>The licensee's 5.03 Dementia Training policy dated August 1, 2021, indicated direct care employees would complete eight (8) hours of initial training within 160 hours of the employment start date; and employees may not provide direct care until the training is complete unless another employee who has the completed the initial training is present for assistance.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01530 | | |
| 01620 SS=F | 144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring<br><br>(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.<br>(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.<br>(e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under | 01620 | | |

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| 01620 | Continued From page 30<br><br>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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure a registered nurse (RN) conducted a reassessment, not to exceed 14 calendar days from the initiation of services; and failed to ensure the registered nurse (RN) conducted ongoing resident monitoring and reassessment not to exceed 90 calendar days from the last date of assessment for two of two residents (R1, R2).<br><br>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).<br><br>The findings include:<br><br>R1<br>R1 was admitted on September 9, 2021, with diagnoses of Korsakoff's syndrome (memory disorder) and cerebral infarction due to unspecified occlusion or stenosis right middle cerebral artery (stroke).<br><br>R1's Service Plan dated September 9, 2021, indicated R1 received services including medication administration and nail care.<br><br>R1's initial comprehensive assessment was | 01620 | | |

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| 01620 | Continued From page 31<br><br>completed on September 9, 2021. R1's record lacked reassessment and monitoring within 14 calendar days after initiation of services.<br><br>R1's record included 90-day nursing assessments dated November 3, 2021, April 27, 2022, May 24, 2022, November 21, 2022, May 2, 2023, and March 25, 2024. The assessment completed April 27, 2022, indicated 175 days had passed since the prior assessment completed on November 3, 2021. The assessment completed November 21, 2022, indicated 181 days had passed since the prior assessment completed on May 24, 2022. The assessment completed May 2, 2023, indicated 162 days had passed since the prior assessment completed on November 21, 2022. The assessment completed on March 25, 2024, indicated 328 days had passed since the prior assessment completed on May 2, 2023.<br><br>R2<br>R2 was admitted on September 5, 2023, with diagnoses of myalgic encephalomyelitis (chronic fatigue syndrome), postural orthostatic tachycardia syndrome (heart rate increases on changing posture), fibromyalgia (widespread pain), and chronic migraine headache.<br><br>R2's Service Plan created on September 6, 2023, signed on September 16, 2023, indicated R1 received services including medication administration, assistance with activities of daily living (dressing, grooming, bathing), housekeeping, nail care, meal assistance, and safety checks.<br><br>R2's initial comprehensive assessment was completed on September 6, 2023. R1's record lacked reassessment and monitoring within 14 calendar days after initiation of services. | 01620 | | |

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| 01620 | Continued From page 32<br><br>R2's record included 90-day nursing assessment dated March 25, 2024. The assessment completed on March 25, 2024, indicated 201 days had passed since the initial assessment completed on September 6, 2023.<br><br>On July 3, 2024, at 11:37 a.m., licensed assisted living director (LALD)-C consulted with registered nurse (RN)-D who stated they were not able to locate a 14-day reassessment for R1 and R2. RN-D stated the assessments were possibly missed due to the transition of the new statues and transitioning from paper to electronic charting at the time. RN-D also stated they thought the assessments were only required yearly.<br><br>The licensee's 6.01 Assessments, Reviews & Monitoring policy dated August 1, 2021, indicated resident reassessment and monitoring would be conducted no more than 14 calendar days after initiation of services and ongoing resident reassessment and monitoring would be conducted as needed based on changes in the needs of the resident and could not exceed 90 calendar days from the last date of the assessment.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01620 | | |
| 01760 SS=F | 144G.71 Subd. 8 Documentation of administration of medication<br><br>Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must | 01760 | | |

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| 01760 | Continued From page 33<br><br>include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure medication administration was documented accurately in the medication administration record (MAR) for six of six residents (R1, R2, R3, R4, R5, R6).<br><br>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).<br><br>The findings include:<br><br>On July 2, 2024, at 7:56 a.m., the surveyor observed unlicensed personnel (ULP)-E gather a one day/four dose pill box that had medications set up by the licensee's nurse and gave it to R2. ULP-E removed the empty one day/four dose pill box that ULP-E reported was from the previous day. ULP-E then proceeded to document all medications were verified and administered on the MAR. However, ULP-E was not observed | 01760 | | |

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| 01760 | Continued From page 34<br><br>verifying the medications in the pill box prior giving to R2. ULP-E did not observe R2 take medications.<br><br>On July 2, 2024, at 8:05 a.m., the surveyor observed ULP-E prepare R3's medications for administration in a disposable medication cup as they documented on the MAR that the medications were verified and administered. ULP-E placed the prepared medications on the kitchen table while the resident was sitting in a recliner in the living room where ULP-E administered R3's eye drops and then walked away. ULP-E did not observe if R3 took the medications.<br><br>On July 2, 2024, at 8:19 a.m., the surveyor observed ULP-E prepare R1's medications for administration in a disposable medication cup as they documented on the MAR that the medications were verified and administered. ULP-E placed prepared medications in a dish on the kitchen table and walked away as ULP-A indicated to ULP-E that R1 was in their room, and they would keep on eye on the medications and make sure R1 took the medications.<br><br>On July 2, 2024, at 8:23 a.m., the surveyor observed ULP-E prepare R4's medications for administration in a disposable medication cup as they documented on the MAR that the medications were verified and administered. ULP-E gave prepared medications to R4 and then walked away. ULP-E did not observe if R4 took the medications.<br><br>On July 2, 2024, at 8:30 a.m., the surveyor observed ULP-E prepare R5's medications for administration in a disposable medication cup as they documented on the MAR that the | 01760 | | |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MORNING GLORY HOMES INC | 18626 CLEARVIEW DRIVE MINNETONKA, MN 55345 |

| (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 |
|---|---|---|---|---|
| 01760 | Continued From page 35<br><br>medications were verified and administered. ULP-E placed the prepared medications on a stand next to R5 in the living room and then walked away to get a glass with water and to prepare a powder medication in the glass of water. ULP-E then placed the glass with water and powdered medication on a stand next the R5 in the living room and then walked away. ULP-E did not observe if R5 took the medications.<br><br>On July 2, 2024, at 8:37 a.m., the surveyor observed ULP-E prepare R6's medications for administration in a disposable medication cup as they documented on the MAR that the medications were verified and administered. ULP-E placed the prepared medications for R6 on the kitchen table and then walked away. ULP-E did not observe if R6 took the medications.<br><br>ULP-E was hired for licensee on November 4, 2023.<br><br>On July 5, 2024, at 3:40 p.m., clinical nurse supervisor (CNS)-B stated all staff were trained on proper medication administration per the licensee's policy and stated staff were to first verify the medication to be administered on the MAR, administer the medication, and then document if medication was administered or refused.<br><br>The licensee's 7.22 Medication and Treatment Record - Documentation & Refusal policy dated August 1, 2021, indicated the licensee would create and maintain a correct and accurate medication record for each resident who received medication assistance or administration. Also, the policy indicated documentation would be completed by the person who performed the task | 01760 | | |

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|---|---|---|---|---|
| 01760 | Continued From page 36<br>immediately after they provided medication assistance or administration.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01760 | | |
| 01880 SS=F | 144G.71 Subd. 19 Storage of medications<br><br>An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure medications were stored securely for six of six residents (R1, R2, R3, R4, R5, R6) with medication management services.<br><br>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).<br><br>The findings include:<br><br>On July 2, 2024, between 8:00 a.m. to 8:40 a.m., the surveyor observed unlicensed personnel (ULP)-E prepare and administer medications for | 01880 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| 01880 | Continued From page 37<br><br>each resident (R1, R2, R3, R4, R5, R6). ULP-E would remove each resident's medications from a locked cabinet in an open container and place them on top of a dryer for ULP-E to prepare medications for administration. ULP-E failed to secure or lock up each resident's medications after preparing the medication and before leaving the medications while assisting each resident with their medication administration in another room.<br><br>On July 2, 2024, at 8:39 a.m., the surveyor observed R2 ambulate to the common area by the dryer where R6's medications were left sitting out in an unsecured open container on top of the dryer by ULP-E as they assisted R6 with medication administration in another room.<br><br>On July 5, 2024, at 3:05 p.m., clinical nurse supervisor (CNS)-B stated all staff have been trained to securely lock all medications managed by the licensee. CNS-B stated ULP-E should have put medications back in the medication cabinet after accessing the medications and prior to giving prepared medications to the residents.<br><br>The licensee's 7.11 Medication Storage policy dated July 30, 2021, indicated when medications were managed and stored by licensee, the medications would be securely locked.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01880 | | |
| 02310 SS=I | 144G.91 Subd. 4 (a) Appropriate care and services<br><br>(a) Residents have the right to care and assisted | 02310 | | |

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|---|---|---|---|---|
| 02310 | Continued From page 38<br><br>living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for one resident (R1) who had bed rails. This resulted in an immediate order on July 1, 2024.<br><br>This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>R1<br>On July 1, 2024, at 12:00 p.m., the surveyor observed R1's bed had a consumer style bed rail attached on the upper left side of the bed. The bed rail were grabbed by the surveyor and was noted to be secured and not loose when the surveyor pushed and pulled on it.<br><br>R1 was admitted on September 9, 2021, with diagnoses of Korsakoff's syndrome, cerebral infarction due to unspecified occlusion or stenosis right middle cerebral artery.<br><br>R1's assessment dated May 3, 2023, indicated | 02310 | | |

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| 02310 | Continued From page 39<br><br>under bed safety, siderail was appropriate based on assessed needs of the resident and indication for bed modifications and bedrail included reasons for safety and fall prevention due to history of stroke. R1's assessment on May 3, 2021, was the last assessment of R1's bedrails.<br><br>R1's most recent assessment dated March 25, 2024, indicated under bed safety, no assistive devices needed for bed. R1's assessment on March 25, 2024, lacked any other information on bedrails or bed safety.<br><br>R1's record lacked an assessment of the bed rail device to include:<br>-purpose and intention of the bed rail;<br>-condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail;<br>-the resident's bed rail use/need assessment;<br>-risk vs. benefits discussion (individualized to each resident's risks);<br>-the resident's preferences;<br>-installation and use according to manufacturer's guidelines;<br>-physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation;<br>-any necessary information related to interventions to mitigate safety risk or negotiated risk agreements; and<br>-evidence the device had not been recalled.<br><br>On July 1, 2024, at 3:25 p.m., clinical nurse supervisor (CNS)-B stated R1's bedrail was initiated May 24, 2022, due to R1's left sided weakness and unstable gait, and R1's family requested it. CNS-B stated this was discontinued by R1's physical therapist; however, R1 continued to use the siderail and it was not removed. | 02310 | | |

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| 02310 | Continued From page 40<br><br>CNS-B further stated they did not realize they needed to continue to assess it.<br><br>The licensee's 6.28 Side rails policy dated August 1, 2021, indicated licensee would ensure rails were FDA compliant, measurements were within the FDA's guidelines, and risk versus benefits would be discussed and documented in the resident's record.<br><br>The Food and Drug Administration's (FDA), A Guide to Bed Safety, revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe."<br><br>The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently Asked Questions (FAQs) indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, | 02310 | | |

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| 02310 | Continued From page 41<br><br>"Documentation about a resident's bed rails includes, but is not limited to:<br>- Purpose and intention of the bed rail;<br>- Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail;<br>- The resident's bed rail use/need assessment;<br>- Risk vs. benefits discussion (individualized to each resident's risks);<br>- The resident's preferences;<br>- Installation and use according to manufacturer's guidelines;<br>- Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and<br>- Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements".<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Immediate<br><br>On July 3, 2024, the immediacy of correction order 2310 was removed, however non-compliance remained at an scope and level of l. | 02310 | | |

Minnesota Department of Health
Food, Pools, & Lodging Services
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *07/02/24*
Time: 10:00:00
Report: 8041241121

# Food and Beverage Establishment Inspection Report



**Location:**
Morning Glory Homes Inc
18626 Clearview Drive
Minnetonka, MN55345
Hennepin County, 27

**Establishment Info:**
ID #: 0038461
Risk:
Announced Inspection: No

**License Categories:**

Expires on: / /

**Operator:**

Phone #: 9526070725
ID #:

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

The following orders were issued during this inspection.

**2-100 Supervision**

***2-102.12AMN***

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

ESTABLISHMENT DOES NOT HAVE A CERTIFIED FOOD PROTECTION MANAGER. KEN KOHN RECENTLY TOOK APPROVED FOOD SAFETY COURSE AND STILL NEEDS TO TAKE TEST AND APPLY FOR STATE CFPM CERTIFICATE.

*Comply By: 08/02/24*

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

***3-305.11A***

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

FOOD CONTAINERS STORED ON THE FLOOR IN THE DRY STORAGE CLOSET.

*Comply By: 07/02/24*

**6-300 Physical Facility Numbers and Capacities**

***6-301.14A***

MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands

LEFT SIDE OF TWO BASIN SINK IN KITCHEN USED FOR HANDWASHING UNTIL THE SEPARATE HAND SINK IS INSTALLED. NO HANDWASHING SIGN PROVIDED.

*Comply By: 07/09/24*

**6-500 Physical Facility Maintenance/Operation and Pest Control**

***6-501.12A***

MN Rule 4626.1520A Clean and maintain all physical facilities clean.

BUILD-UP OF DUST ON THE CEILING ABOVE THE MICROWAVE.

*Comply By: 07/09/24*

**Food and Equipment Temperatures**

Process/Item: Cold Holding
Temperature: 41 Degrees Fahrenheit - Location: upright true cooler: chicken salad
Violation Issued: No

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: upright true cooler: yogurt
Violation Issued: No

| Total Orders In This Report | Priority 1 | Priority 2 | Priority 3 |
|---|---|---|---|
| | 0 | 0 | 4 |

Inspection was completed with Ken and Lucy Kohn. Rhawnie Quinehan was the lead Health Regulation Division Nurse Evaluator. Facility had six residents on site at time of inspection.

This establishment has a residential kitchen. Food must be prepared for same day service only. The kitchen has wood cabinets with a hollow base, tiles flooring and a popcorn ceiling.

A two basin sink is located in the kitchen. One basin must be designated for handwashing until the separate handwashing sink is installed. Establishment has a Frigidaire dishwasher that has a sani rinse/high temp cycle and achieved a temp at least 160F for sanitizing dishes.

Discussed the following:
-Employee illness policy and logging requirements
-Handwashing
-Glove-use and bare hand contact
-Pest control
-Food storage and preventing cross contamination
-Date marking
-Restrictions concerning serving a highly susceptible population
-Vomit clean up process
-Proper cold holding

Type: Full
Date: *07/02/24*
Time: 10:00:00
Report: 8041241121
Morning Glory Homes Inc

# 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 8041241121 of 07/02/24.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

**Inspection report reviewed with person in charge and emailed.**

Signed:_____
Lucy Kohn
Operator

Signed:_____
Sarah Conboy
Public Health San. Supervisor
651-201-3984
sarah.conboy@state.mn.us