Electronically Delivered

December 1, 2023

Licensee
Norbella Centerville
2025 Michaud Way
Centerville, MN 55038

RE: Project Number(s) SL39268015

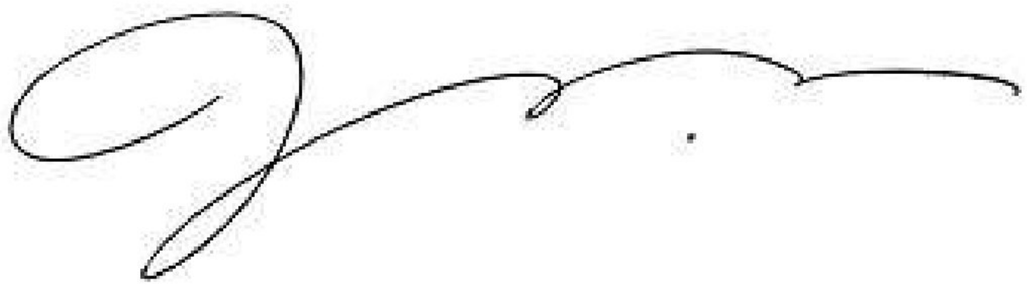
Dear Licensee:

On November 20, 2023, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the September 15, 2023, survey were corrected. This follow-up survey verified that the faciility 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

PMB

Electronically Delivered
September 28, 2023

Licensee
Norbella Centerville
2025 Michaud Way
Centerville, MN 55038

RE: Project Number(s) SL39268015

Dear Licensee:

This is your **official notice** that you have been **granted your assisted living facility license with dementia care.** Your license effective and expiration dates remain the same as on your provisional license. Your updated status will be listed on the license certificate at renewal and **this letter serves as proof** in the meantime. If you have not received a letter from us with information regarding renewing your license within 60 days prior to your expiration date, please contact us at (651) 201-5273 or by email at Health.assistedliving@state.mn.us.

The Minnesota Department of Health completed an initial survey on September 15, 2023, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

STATE CORRECTION ORDERS
The enclosed State Form documents the state correction orders. The Department of Health documents state correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Home Care 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 are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

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

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

In accordance with Minn. Stat. § 144G.20, Subd. 4(a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572. Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4(a)(5)(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

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

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00

The total amount you are assessed is $500.00. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document 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 residents/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

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

A state 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
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. Requests for hearing may be emailed to: **Health.HRD.Appeals@state.mn.us**.

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration or a hearing, but not both.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and/or 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
	39268	A. BUILDING: _____ B. WING _____	09/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORBELLA CENTERVILLE	2025 MICHAUD WAY CENTERVILLE, MN 55038

(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: SL39268015-0 On September 11, 2023, through September 14, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 19 active residents receiving services under the provisional Assisted Living with Dementia Care license. The immediacy of order 2310 was removed on September 13, 2023 based on supervisor review. The scope and level remain unchanged.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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.	
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that	0 510		

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0 510	Continued From page 1 complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control related to glove use for two of two unlicensed personnel ((ULP)-E, ULP-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-E was hired May 10, 2023, and ULP-F was hired September 27, 2022. ULP-E On September 12, 2023, at 7:10 a.m. during continuous observation, ULP-E donned (put on)	0 510		

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0 510	Continued From page 2 gloves without the completion of hand hygiene. ULP-E then provided medication administration to a resident. Once medications were administered, ULP-E then doffed (took off) gloves and did not complete hand hygiene. ULP-E escorted the resident to the common area and assisted the resident to sit in a chair in preparation for breakfast. ULP-E then proceeded to the hand washing sink and completed hand hygiene. ULP-F On September 12, 2023, at 8:30 a.m. during continuous observation, ULP-F donned gloves without the completion of hand hygiene. ULP-F completed a blood glucose check and administration of insulin to R2. ULP-F then doffed the gloves and failed to complete hand hygiene. ULP-F proceeded to the medication cart, returned the blood glucose monitor device, returned the insulin pens, and then documented on the computer. ULP-F then completed hand hygiene with hand sanitizer located on the medication cart. On September 13, 2023, at 12:00 p.m., clinical nurse supervisor (CNS)-D stated the licensee's expectations are all staff are to complete hand hygiene immediately before donning and immediately after doffing gloves. The licensee's Procedure for Using Gloves policy dated July 23, 2021, indicated hand hygiene would be completed prior to donning and after doffing gloves. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		

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0 810	Continued From page 3	0 810		
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 activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by:	0 810		

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0 810	Continued From page 4 Based on record review and interview, the licensee failed to complete the required employee evacuation drills. This had the potential to affect all employees, 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 September 13, 2023, between 1:25 p.m. and 2:00 p.m., documents were reviewed by survey staff. The licensee failed to meet the required evacuation drill frequency. Evacuation drill records were provided dated 03-08-2023 fire drill at 10:00 a.m., 04-19-2023 tornado drill at 2:00 p.m., and 09-13-2023 gas leak event at 2:53 p.m. The evacuation drill frequency of twice per year per shift with at least one evacuation drill every other month was not met. This deficient condition was verified by the licensed assisted living director (LALD)-C and maintenance director (MD)-G on September 13, 2023, at approximately 2:05 p.m. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		

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01730	Continued From page 5	01730		
01730 SS=F	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 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.	01730		

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01730	Continued From page 6 (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 develop an individualized medication management record with the required content for two of two residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2 R2 was admitted on April 27, 2023. R2's Master Assessment dated July 31, 2023, indicated under section Medication Management R2 received oral medications three (3) times daily and topical medications two (2) times daily. R2's untitled documented dated September 12, 2023, identified by clinical nurse supervisor (CNS)-D as R2's service plan, indicated R2 started, "Service Type: Oral Med 3x daily," on April 27, 2023. R3 R3 was admitted on June 5, 2023.	01730		

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01730	Continued From page 7 R3's Master Assessment dated September 5, 2023, indicated under Section 6. Medication Management R3 received oral medications 3 times daily. R3's untitled documented dated September 7, 2023, identified by CNS-D as R3's service plan, indicated R3 started, "Service Type: Oral Med 3x daily," on June 15, 2023. R2 and R3's record both lacked a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions and identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis as required for medication management records. On September 12, 2023, at 11:00 a.m. CNS-D stated the licensee's medication management record had not been developed to identify who would be responsible for refills and how medications would be stored. CNS-D stated licensee would need to add those components to the medication management record for all residents receiving medication services. The licensee's Individualized Medication, Treatment & Therapy Management Plans policy dated May 24, 2022, indicated storage of medication and person responsible for refills would be included in all medication management records. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		

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01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop a treatment management record to include all required content for one of two residents (R2) with treatments. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 was admitted on April 27, 2023. R2's Master Assessment dated July 31, 2023, indicated under section Diabetes Mellitus R2 received glucose checks three (3) times per day. R2's untitled documented dated September 12, 2023, identified by clinical nurse supervisor	01970		

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01970	Continued From page 9 (CNS)-D as R2's service plan, indicated R2 started, "Service Type: Glucose Check 3x daily," on April 27, 2023. R2's Service Checkoff List dated September 2023, indicated R2 received blood glucose checks 3 times per day at 8:00 a.m., 12:00 p.m., and 5 p.m. R2's Physician Order Sheet signed September 8, 2023, lacked an order for R2's blood glucose checks. On September 12, 2023, at 11:30 a.m., clinical nurse supervisor (CNS)-D stated R2's record lacked a provider's order for blood glucose checks. CNS-D obtained orders from R2's provider on September 12, 2023, for blood glucose checks 3 times daily. The licensee's Renewal of Medication, Treatment or Therapy Prescriptions and Orders policy dated August 23, 2021, indicated all medication and treatment orders would be current. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		
02170 SS=D	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills;	02170		

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02170	Continued From page 10 (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individualized activity plan contained all required content for one of two residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	02170		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39268	A. BUILDING: _____ B. WING _____	09/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORBELLA CENTERVILLE	2025 MICHAUD WAY CENTERVILLE, MN 55038

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02170	Continued From page 11 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3 was admitted on June 5, 2023, and at the time of the survey resided in the licensee's secured unit. R3's untitled documented dated September 7, 2023, identified by CNS-D as R3's service plan, indicated R3 started, "Service Type: Activities: Reminders," on June 16, 2023. R3's undated Life Enrichment Interests identified by licensed assisted living director (LALD)-C as R3's evaluation for activities, had multiple blank sections including required sections for behavioral interventions and adaptations necessary for R3 to participate. On September 13, 2023, at 9:45 a.m., LALD-C clarified the required questions were included in the evaluation for activities however the required sections were not competed as the licensee required. LALD-C stated the licensee's expectation was each section of the evaluation would be fully completed and implemented into each resident's unique activity plan. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02170		

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02310	Continued From page 12	02310		
02310 SS=D	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted 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. This MN Requirement is not met as evidenced by: 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 of two residents (R2) with bed rails. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 was admitted on April 27, 2023. On September 12, 2023, at 8:30 a.m. during continuous observations, unlicensed personnel (ULP) assisted R2 from their hospital bed with bed rails to their wheelchair with the use of a gait belt and a security pole. The security pole was a transfer assistive device that was installed by pressure mount from the floor to ceiling. The device was a white pole with a two-handle point which allowed R2 to grab and pull himself up,	02310		

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02310	Continued From page 13 stabilize self, and seat self in R2's wheelchair. R2 stated they use the pole for transfers, and it was installed by their family member. The surveyor grabbed and pulled on the safety pole and noted the pole was secured to the ceiling and floor. R2's Master Assessment dated July 31, 2023, indicated R2 used a Bed Rails/Device for assistive equipment. The assessment indicated the type of bed rail device as, "A. Bed rail on hospital bed." The assessment lacked identification R2 also used a "Security Pole," style assistive device. R2's untitled documented dated September 8, 2023, identified by clinical nurse supervisor (CNS)-D as R2's service plan, indicated R2 received bed mobility and transfer assistance from an ULP multiple times a day. The service plan included instructions for positioning and transferring in and out of R2's bed. On September 12, 2023, at 10:30 a.m., CNS-D stated an assessment related to the security pole was not completed by the licensee. CNS-D stated the bed rails were assessed and found to be safe, but the security pole was not included in any assessment for R2. CNS-D stated the licensee was aware of the security pole but had not completed the required assessment on the security pole. CNS-D stated they had recently started working on August 28, 2023, and had not completed an assessment on R2 as an assessment was not due. CNS-D stated the nurse who previously held the position as CNS was instructed to add the security pole to R2's assessment but had not completed it prior to quitting. CNS-D stated they would have added the security pole to the assessment had they completed an assessment on R2.	02310		

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02310	Continued From page 14 The licensee's Assessing the Safety of Side Rails policy dated January 23, 2023, indicated a registered nurse's assessment would be completed on all side rails or similar equipment. No further information provided. TIME PERIOD FOR CORRECTION: Immediate The immediacy of order 2310 was removed on September 13, 2023 based on supervisor review. The scope and level remain unchanged.	02310		