Electronically Delivered

June 30, 2025

Licensee
Armstrong Homes Inc
7908 Oregon Avenue North
Brooklyn Park, MN 55445

RE: Project Number(s) SL36204016

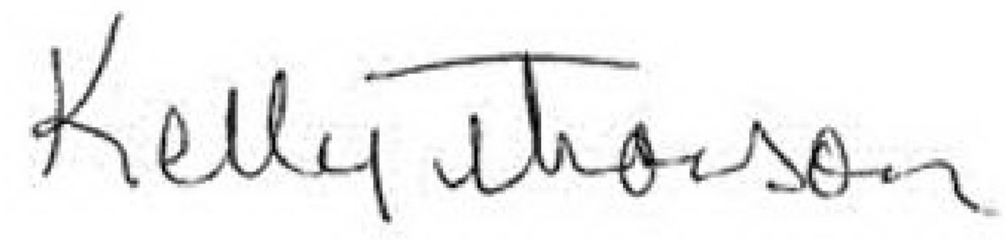
Dear Licensee:

On May 13, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on October 23, 2024. 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,



Kelly Thorson, Supervisor
State Evaluation Team
Email: Kelly.Thorson@state.mn.us
Telephone: 320-223-7336 Fax: 1-866-890-9290

HHH

Electronically Delivered

February 26, 2025

Licensee
Armstrong Homes Inc.
7908 Oregon Avenue North
Brooklyn Park, MN 55445

RE: Project Number(s) SL36204016

Dear Licensee:

On January 21, 2025, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on October 23, 2024. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the October 23, 2024 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on October 23, 2024, found not corrected at the time of the January 21, 2025, follow-up survey and/or subject to penalty assessment are as follows:

2310 - Appropriate Care And Services - 144g.91 Subd. 4 (a) - $3,000.00

The details of the violations noted at the time of this follow-up survey completed on January 21, 2025 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

Also, at the time of this follow-up survey completed on January 21, 2025, we identified the following violation(s):

0775 - Fire Protection And Physical Environment - 144g.45 Subd. 2. (a)
0780 - Fire Protection And Physical Environment - 144g.45 Subd. 2 (a) (1)

The details of the violation(s) noted at the time of this follow-up survey are delineated on the attached State Form. Only the ID Prefix Tag in the left hand column without brackets will identify these state correction orders. It is not necessary to develop a plan of correction.

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 outlined on the state form; however, plans of correction are not required to be submitted for approval.

IMPOSITION OF FINES:
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.

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.

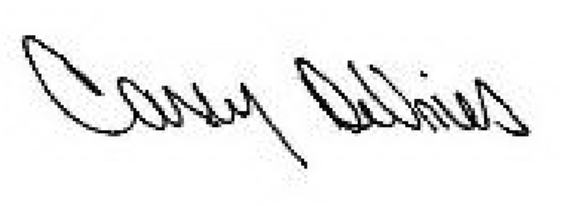
To submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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.

We urge you to review these orders carefully. If you have questions, please contact Casey DeVries at 651-201-5917.

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.

Sincerely,



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

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36204	A. BUILDING: _____ B. WING _____	R 01/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARMSTRONG HOMES INC	7908 OREGON AVENUE NORTH BROOKLYN PARK, MN 55445

(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 FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SL36204016-1 On January 21, 2025, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on October 23, 2024. At the time of the survey, there were three residents all of whom received services under the Assisted Living License. As a result of the follow-up survey, the following orders were reissued and/or new orders issued.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	

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{0 660}	Continued From page 1	{0 660}		
{0 660} SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (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. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by:	{0 660}	Not reviewed during this survey.	
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor;	{0 680}		

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{0 680}	Continued From page 2 and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by:	{0 680}	Not reviewed during this survey.	
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to keep the facility in compliance with the Minnesota Fire Code. The deficient condition has the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic	0 775		

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0 775	Continued From page 3 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During a facility tour with owner (O)-B and (O)-E on January 21, 2025, between 11:30 a.m., and 12:30 p.m., the following deficient conditions were observed: OXYGEN TANK: The surveyor observed that the oxygen tank in R1's room was not properly secured. The surveyor explained to O-B and O-E that all oxygen tanks shall be properly secured. EMERGENCY ESCAPE WINDOW BLOCKED: The surveyor observed that the emergency escape window was blocked by the bed in R1's room. The surveyor explained to O-B and O-E that the emergency escape windows shall be always accessible and not blocked. FAN: The surveyor observed that the fan in R1's room was covered in lint/dust blocking the air intake. The surveyor explained to O-B and O-E that the fan shall be cleaned periodically to prevent the buildup of lint/dust. STORAGE: The surveyor observed that the storage in R1's	0 775		

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0 775	Continued From page 4 room was excessive. There was barley room to move in the room and the storage was packed around the freezer and refrigerator. The storage was blocking access to the emergency escape window and exiting from the room in an emergency. The surveyor explained to O-B and O-E that the storage shall be reduced to a safe level so the emergency escape window can be safely accessed as well as access from the room and that the storage around the freezer, refrigerator and oxygen tanks shall be reduced to a safe level. The deficient conditions were visually verified by O-B and O-E accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to	0 780		

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0 780	Continued From page 5 operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that are interconnected so that the actuation of one alarm causes all alarms in the dwelling unit to actuate. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During a facility tour with owner (O)-B and (O)-E on January 21, 2025, between 11:30 a.m., and 12:30 p.m., the following deficient condition was observed: SMOKE ALARMS: The surveyor observed that the smoke alarms in the facility were not interconnected.	0 780		

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0 780	Continued From page 6 The surveyor explained to O-B and O-E that all smoke alarms in the facility shall be interconnected, meaning when one activates, they all activate. The deficient condition was visually verified by O-B and O-E accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
{01370} SS=E	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating;	{01370}		

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{01370}	Continued From page 7 (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by:	{01370}	Not reviewed during this survey.	
{01380} SS=F	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required.	{01380}		

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{01380}	Continued From page 8 This MN Requirement is not met as evidenced by:	{01380}	Not reviewed during this survey.	
{01470} SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the staff member will be providing and	{01470}		

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{01470}	Continued From page 9 the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by:	{01470}	Not reviewed during this survey.	
{01530} SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must	{01530}		

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{01530}	Continued From page 10 have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by:	{01530}	Not reviewed during this survey.	
{01610} SS=E	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan 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. If necessitated by either the geographic	{01610}		

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{01610}	Continued From page 11 distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. This MN Requirement is not met as evidenced by:	{01610}	Not reviewed during this survey.	
{01620} SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.	{01620}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36204	A. BUILDING: _____ B. WING _____	R 01/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARMSTRONG HOMES INC	7908 OREGON AVENUE NORTH BROOKLYN PARK, MN 55445

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{01620}	Continued From page 12 This MN Requirement is not met as evidenced by:	{01620}	Not reviewed during this survey.	
{01750} SS=E	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by:	{01750}	Not reviewed during this survey.	
{02310} SS=I	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,	{02310}		

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{02310}	Continued From page 13 medical or nursing standards for one of one resident (R1) who utilized bed rails. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 admitted to the licensee on November 29, 2023, and began receiving assisted living services. R1's diagnoses included conversion disorder (mental health issue disrupts how the brain works, leading to real, physical symptoms a person cannot control) with seizures, obsessive-compulsive disorder (OCD), chronic pain syndrome, chronic obstructive pulmonary disease (COPD), type 2 diabetes mellitus (DM2), bipolar disorder (mental health disorder characterized by extreme mood swings), borderline personality disorder, anxiety disorder, and depressive disorder. R1's Service Plan (Waiver) -Addendum to Contract signed August 22, 2024, indicated R1 received assistance with ambulation, bathing, dressing, grooming, housekeeping, laundry, behavior management, meals, safety checks, shopping assistance, socialization, and transportation. On January 21, 2025, at 9:50 a.m., the surveyor	{02310}		

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{02310}	Continued From page 14 observed a hospital bed with bilateral (two sides) quarter rail hospital-style bed rails firmly attached at the head of the hospital bed. R1's most recent assessment completed October 31, 2024, indicated R1's hospital bed did not have bed rails and R1 had removed their bed rails and placed them into the licensee's garage. In addition, the assessment indicated clinical nurse supervisor (CNS)-C discussed risks and benefits for bed rails in the event R1 wanted to place the bed rails back onto their bed. R1's record lacked current assessment of: - purpose and intention of the bed rail; - type of bed rail utilized; - documentation of R1's cognitive and physical status as they pertain to bed rails to determine the intended purpose for the bed rail and whether R1 was at a high risk for entrapment or falls; - documentation whether the bed rail has the effect of being an improper restraint; - documentation of bed rail measurements; - documentation of a physical inspection of the bed rail and mattress for areas of entrapment, stability, and correct installation; On January 21, 2025, at 10:44 a.m., owner (O)-B stated R1's record did not have any additional assessment completed after October 31, 2024. On January 21, 2025, at 10:49 a.m., R1 stated they removed their bed rail for one week however, the mattress moved so they placed bed rails back onto their bed. On January 21, 2025, at 10:50 a.m., CNS-C stated when they completed R1's assessment they visually confirmed the bed rails were removed and placed in the licensee's garage.	{02310}		

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{02310}	Continued From page 15 CNS-C stated they reviewed risks and benefits of having a bed rail during the assessment in October. CNS-C stated they were not aware R1 had bed rails on their bed, and they did not know when R1 placed the bed rails back onto the bed. CNS-C stated R1 did not allow staff to enter their room, which was why they did not know R1 had bed rails on their bed. CNS-C stated if R1 placed bed rails, R1 should have notified the licensee because they were "capable to manage cares and then I would come back" to complete a bed rail assessment. The surveyor inquired if staff monitored for new devices. CNS-C stated they had not been informed by staff a bed rail was on R1's bed. CNS-C stated they would be willing to come to the facility on January 22, 2024, to complete a bed rail assessment if R1 would allow them to. On January 21, 2025, at 1:39 p.m., CNS-C stated they told R1 to notify them if they placed the bed rails back onto their bed, and unlicensed personnel (ULP) were trained to notify the nurse with any changes in condition or new devices. On January 21, 2025, at 1:48 p.m., ULP-A stated they were not aware R1's bed had bed rails. ULP-A stated it was hard to tell if they were on due to the large number of belongings being stored in R1's room. ULP-A stated they were not trained to notify a nurse if they noticed a resident with a new device. The Food and Drug Administration's (FDA), A Guide to Bed Safety, dated December 11, 2017, indicated following information: "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	{02310}		

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{02310}	Continued From page 16 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." The Minnesota Department of Health (MDH) document titled Resources & Frequently - Asked Questions (FAQs) dated October 15, 2024, read, "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. Additionally, the licensee must ensure the bed rail is securely attached to the bed frame per manufacturer guidelines. This includes consideration of any identified contradictions of use such as height/weight restrictions, age, mattress, bed frame set up, etc." In addition, the document read, "Even when bed rails are used according to manufacturer's guidelines, they can present a hazard. The licensee must ensure the resident and/or resident's responsible party has been educated on the risk for injury up to and including death due to entrapment." The document continued to read, "Best practice for documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail - Measurements - The resident's bed rail use/need assessment - Risk vs. benefits discussion (individualized to each resident's risks)	{02310}		

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{02310}	Continued From page 17 - The resident's preferences - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements" In addition, the Minnesota Department of Health (MDH) document titled Resources & Frequently - Asked Questions (FAQs) dated October 15, 2024, read "If any aspect of patient care is not documented, it is viewed as not having been completed." The licensee's 6.28 Side Rail policy dated January 6, 2024, indicated when the licensee was aware of a resident utilizing side rails on a bed, the licensee would assess the use, educate the resident, and when appropriate, the responsible person, regarding the risks and benefits of siderails, and verify that the side rail in use was of safe design and utilized consistent with the manufactures instructions. In addition, for the licensee to consider the bed rail safe it would be consistent with the FDA's 2006 dimensional measurement to reduce entrapment which indicated all zones would not exceed 4.75 inches. No further information was provided.	{02310}		

Electronically Delivered

November 26, 2024

Licensee
Armstrong Homes Inc
7908 Oregon Avenue North
Brooklyn Park, MN 55445

RE: Project Number(s) SL36204016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on October 23, 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.

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

St - 0 - 0495 - 144g.41 Subd. 1 (14) - Minimum Requirements - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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

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

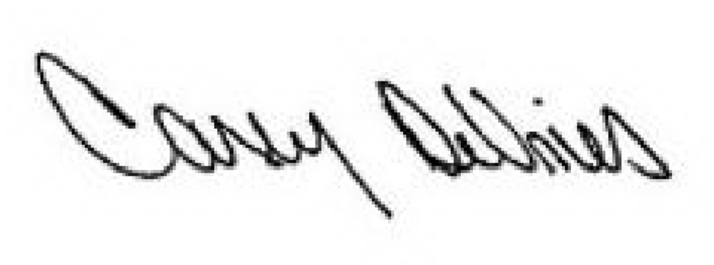
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms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

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

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

If you have any questions, please contact me.

Sincerely,



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

HHH

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0 000	Initial Comments 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: SL36204016-0 On October 21, 2024, through October 23, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were four residents all of whom received services under the Assisted Living Facility license. An immediate correction order was identified on October 21, 2024, issued for SL36204016-0, tag identification 0495. During the survey, the licensee took action to mitigate the immediate risk. However, noncompliance remained, and 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 Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 495 SS=I	144G.41 Subd. 1 (14) Minimum Requirements (14) provide staff access to an on-call registered	0 495		

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0 495	Continued From page 1 nurse 24 hours per day, seven days per week This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure that a registered nurse was available on-call 24 hours a day, seven days per week. This had the potential to affect all residents and staff of the facility. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's facility had a current census of four residents. R1 R1 admitted to the licensee on November 29, 2023, and began receiving assisted living services. R1's diagnoses included conversion disorder (mental health issue disrupts how the brain works, leading to real, physical symptoms a person cannot control) with seizures, obsessive-compulsive disorder (OCD), chronic pain syndrome, chronic obstructive pulmonary disease (COPD), type two diabetes (DM2), bipolar disorder (mental health disorder characterized by extreme mood swings), borderline personality disorder, anxiety disorder,	0 495	During the survey, the licensee took action to mitigate the immediate risk. However, noncompliance remained, and the scope and level remain unchanged.	

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0 495	Continued From page 2 and depressive disorder. R1's Service Plan (Waiver)-Addendum to Contract signed August 22, 2024, indicated R1 received behavior management from the licensee. R2 R2 admitted to the licensee on June 1, 2024, and began receiving assisted living services. R2 diagnoses included DM2, bipolar disorder, personality disorder, anxiety disorder, post-traumatic stress disorder (PTSD), major depressive disorder, schizoaffective disorder (mental health condition that is marked by a mix of schizophrenia symptoms such as hallucinations and delusions, and mood disorder symptoms). R2's Service Plan (Private) - Addendum to Contract signed October 21, 2024, indicated R2 received behavior management and medication administration from the licensee. R3 R3 admitted on April 1, 2024, and began receiving assisted living services. R3's diagnoses included schizoaffective disorder, anxiety disorder, depression, bipolar disorder, and OCD. R3's Service Plan (Waiver) - Addendum to Contract signed August 17, 2024, indicated R3 received behavior management and medication administration from the licensee. R4 R4 admitted to the license on February 27, 2024,	0 495		

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0 495	Continued From page 3 and began receiving assisted living services. R4's diagnoses included schizophrenia, and mild cognitive impairment. R4's Service Plan (Waiver) -Addendum to Contract signed August 17, 2024, indicated R4 received behavior management and medication administration from the licensee. On October 21, 2024, at approximately 9:30 a.m., during the entrance conference, owner (O)-B stated clinical nurse supervisor (CNS)-C was the only registered nurse (RN) employed by the licensee at the time of the survey. O-B stated CNS-C worked another registered nurse position at a hospital. O-B stated CNS-C was able to be reached by text or phone when needed. O-B stated the licensee was in the process of hiring another registered nurse to be able to assist the licensee when CNS-C was unavailable. O-B stated the expected return time frame was a couple of minutes for CNS-C to return a phone call. On October 21, 2024, at 10:25 a.m., at 10:25 a.m., CNS-C stated they worked 12-hour shifts at a hospital five days every two weeks as a floor nurse providing direct bedside care to patients. CNS-C stated they asked the licensee's staff to text them if there was a resident concern and depending on the need, they could either text or call the staff member back after they finished providing bedside cares at the hospital. CNS-C stated they had trained the licensee's staff on what to do in case of an emergency and staff "do not hesitate to just call 911" if they need to. CNS-C stated they began employment in November 2023 and have been the only RN employed with the licensee since. CNS-C stated	0 495		

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0 495	Continued From page 4 they recently had a discussion with the owners to hire another RN in case they were ever not available. CNS-C stated the owners were in the process of hiring a new RN however they did not know where they were in the process. On October 21, 2024, at 10:59 a.m., the surveyor inquired where the licensee was at in the hiring process for a new RN. O-B stated the licensee was running a background study in the next week for one and they should start training with CNS-C within two weeks. The licensee's 6.12 Availability of an RN for Staff policy dated July 20, 2021, indicated the licensee would have a RN available for consultation by staff performing delegated nursing tasks and must have an appropriate licensed health professional available if performing other delegated serivces such as therapies. The RN must be readily available either in person, by telephone, or by other means to the staff at times when the staff are providing services. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	0 495		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (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	0 660		

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0 660	Continued From page 5 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. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), to include a two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test for one of four employees (unlicensed personnel (ULP)-A). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-A was hired on March 14, 2024, to provide direct care services to residents. ULP-A's employee record included a document titled Baseline TB Screening Tool for Health Care Workers (HCWs) dated March 16, 2024. The form included the health history screen and an	0 660		

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0 660	Continued From page 6 area to record a TST or TB blood test. The TST and /or TB blood test was not completed. ULP-A's record lacked a two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test. On October 23, 2024, at 8:09 a.m., owner (O)-B stated new employees completed a health history screening and would provide the licensee with a negative TB test from a clinic. On October 23, 2024, at 9:14 a.m., clinical nurse supervisor (CNS)-C stated a new employee would provide management with their TB screening completed by their provider. CNS-C stated they advise management on what TB paperwork was needed in the employee record. On October 23, 2024, at 10:07 a.m., licensed assisted living director (LALD)-D stated new employees needed to provide a chest Xray or TB blood test within 160 hours of date of hire. LALD-D stated once they received the paperwork they placed it into the employee file. LALD-D verified ULP-A record lacked a TB screening and stated they have seen ULP-A's results however, they were unable to locate them. The CDC's document titled Baseline Tuberculosis Screening and Testing for Health Care Personnel dated December 19, 2023, recommended all health care personnel should be screened for TB upon hire and the TB screening process included: - a baseline individual TB risk assessment; - TB symptom evaluation; and - a TB test which could include TB blood test or TB skin test. The licensee's 8.16 Tuberculosis Screening policy dated July 20, 2021, indicated the licensee	0 660		

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0 660	Continued From page 7 would establish and maintain a comprehensive TB infection control program according to the most current TB infection control guidelines issued by the CDC. In addition, new staff would have a blood test or a two-step TST conducted with results documented on the Baseline TB Screening Tool for HCWs. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site.	0 680		

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0 680	Continued From page 8 (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's undated emergency disaster preparedness plan comprised of documents in a binder lacked evidence of the following required content: - a missing resident plan and quarterly review of the missing resident plan; - development of emergency plan (EP) to consider emerging infectious diseases; - hazard vulnerability risk assessment; - strategies for addressing facility and community based risks to include staffing surges and shortages; - EP program patient population to include specific roles in another's absence through succession planning; - subsistence needs for staff and residents; - policies and procedures (P/P) for medical	0 680		

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0 680	Continued From page 9 documents; - P/P for volunteers; - arrangements with other facilities; - roles declared by secretary; - names and contact information; - emergency officials contact information; and - methods for sharing information. On October 23, 2024, at 10:11 a.m., licensed assisted living director (LALD)-D stated the licensee did not complete a hazard vulnerability assessment. LALD-D stated they reviewed the missing resident policy quarterly, however, did not document the reviews. LALD-D stated they had an agreement with another facility in case of an evacuation however, they were unable to locate the documentation of the agreement. LALD-D verified they did not address waivers declared by secretary in the EPP. The licensee's 9.02 Disaster Planning Emergency Preparedness policy dated January 5, 2024, indicted the licensee "will have in place a general emergency preparedness plan, that is in alignment with facility's requirement to also comply with CMS Appendix Z." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
01370 SS=E	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided;	01370		

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01370	Continued From page 10 (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure trainings were completed for all required skill areas, prior	01370		

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01370	Continued From page 11 to providing services, for two of three unlicensed personnel ((ULP)-A, ULP-G). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-A ULP-A was hired on March 14, 2024, to provide direct care serivces to residents. On October 22, 2024, at 8:40 a.m., the surveyor observed ULP-A administer oral medication to R3. ULP-G ULP-G was hired on February 25, 2024, to provide direct care services to residents. ULP-A and ULP-G's records lacked the following required training: - appropriate and safe techniques in person hygiene and grooming that included use of hearing aids; - basic nutrition, meal preparation, food safety, and assistance with eating; and - preparation of modified diets as ordered by a licensed health professional. On October 23, 2024, at 8:10 a.m., owner (O)-B stated clinical nurse supervisor (CNS)-C	01370		

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01370	Continued From page 12 completed trainings with the ULP. In addition, O-B stated the licensee began to use EduCare (a training software program) two months ago and not all employees had completed assigned classes. On October 23, 2024, at 9:15 a.m., CNS-C stated they did not train ULP on the topics listed above. CNS-C stated if a resident residing in the facility had a modified diet or hearing aids, they would train the ULP on the topics. CNS-C stated they were unaware that the topics listed above were required trainings. The licensee's 5.02 Competency Training Evaluations policy dated January 5, 2024, read, "Training and competency evaluations for all ULPs will include: a) Documentation requirements for all services provided b) Reports of changes in the resident's condition to the supervisor designated by the facility c) Basic infection control, including blood-borne pathogens d) Maintenance of a clean and safe environment e) Appropriate and safe techniques in personal hygiene and grooming, including: i. hair care and bathing ii. care of teeth, gums, and oral prosthetic devices iii. care and use of hearing aids iv. dressing and assisting with toileting f) Training on the prevention of falls g) Standby assistance techniques and how to perform them h) Medication, exercise, and treatment reminders i) Basic nutrition, meal preparation, food safety, and assistance with eating j) Preparation of modified diets as ordered by a licensed health professional	01370		

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01370	Continued From page 13 k) Communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family l) awareness of confidentiality and privacy m) Understanding appropriate boundaries between staff and residents and the resident's family n) Procedures to use in handling various emergency situations o) Awareness of commonly used health technology equipment and assistive devices." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01380 SS=F	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required.	01380		

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01380	Continued From page 14 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure competency evaluations were completed for all required skill areas, prior to providing services, for three of three unlicensed personnel ((ULP)-A, ULP-F, ULP-G). 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: ULP-A ULP-A was hired on March 14, 2024, to provide direct care services to residents. On October 22, 2024, at 8:40 a.m., the surveyor observed ULP-A administer oral medication to R3. ULP-F ULP-F was hired on April 1, 2024, to provide direct care services to residents. ULP-G ULP-G was hired on February 25, 2024, to provide direct care services to residents. ULP-A, ULP-F, and ULP-G's records lacked the following required competency: - range of motion and positioning.	01380		

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01380	Continued From page 15 On October 23, 2024, at 9:15 a.m., clinical nurse supervisor (CNS)-C stated they had not completed a competency evaluation for range of motion or positioning with any ULP. CNS-C stated if a resident residing in the facility required range of motion or positioning services they would train and complete a competency evaluation. CNS-C stated they were unaware that a competency evaluation was required for range of motion and positioning. The licensee's 5.02 Competency Training Evaluations policy dated January 5, 2024, read, "In addition to the above training and competency evaluation for unlicensed personnel providing assisted living services must include: a. Observing, reporting, and documenting resident status b. Basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel c. Reading and recording temperature, pulse, and respirations of the resident d. Recognizing physical, emotional, cognitive, and developmental needs of the resident e. Safe transfer techniques and ambulation f. Range of motioning and positioning g. Administering medications or treatments as required". No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following	01470		

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01470	Continued From page 16 topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following	01470		

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01470	Continued From page 17 topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received orientation to assisted living, including all required content, for one of three employees (clinical nurse supervisor (CNS)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: CNS-C was hired on January 6, 2024, to provide supervision and oversite to unlicensed personnel (ULP), and to provide direct care services to residents. CNS-C's record lacked documentation that the	01470		

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01470	Continued From page 18 following orientation topics were completed: - an overview of assisted living MN statutes 144G; - an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; - handling of emergencies and use of emergency services; - compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); - the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; - handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; - consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and - a review of the types of assisted living services the employee will be providing and the facility's category of licensure. On October 22, 2024, at 11:38 a.m., owner (O)-B stated the surveyor received all of CNS-C's employee record and CNS-C did not complete any training in EduCare (a training software program).	01470		

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01470	Continued From page 19 On October 23, 2024, at 9:20 a.m., CNS-C stated when they began employment with the licensee, they reviewed the job description and nursing policies via email and were orientated to the facility. CNS-C stated they were unable to remember the exact topics discussed when they were hired. The licensee's 5.01 Orientation of Staff and Supervisors & Content dated January 5, 2024, indicated all of the licensee's employees providing and supervising direct services must complete an orientation to assisted living facility licensing requirement and regulations before providing assisted living services to residents. In addition, the policy read, "The orientation must contain the following topics: - An overview of the appropriate Assisted Living statutes and rules - An introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person - Handling of emergencies and use of emergency services - Compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC) - The assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights - Principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person - Handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints - Consumer advocacy services of the Office of	01470		

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01470	Continued From page 20 Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services - A review of the types of assisted living services the employee will be providing and the facility's category of licensure - The staff person's job description upon hire and whenever there is a change to the job description that changes the nature of the job or how the job is to be performed - The facility's organization chart and the roles of staff within the facility, and the services offered by the facility as identified in the uniform checklist disclosure of services - The identification of incidents of maltreatment as defined under Minnesota Statutes, section 626.5572, subdivision 15, including abuse, financial exploitation, and neglect, and an explanation that any act that constitutes maltreatment is prohibited." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01530 SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics	01530		

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01530	Continued From page 21 related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a supervisor of direct-care employees received at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date for one of one nurse (clinical nurse supervisor (CNS)-C). In addition, the licensee failed to ensure direct-care staff received at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date for two of three direct care employees (unlicensed personnel (ULP)-A, ULP-G). 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	01530		

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01530	Continued From page 22 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: CNS-C CNS-C was hired on January 6, 2024, to provide supervision and oversite to ULP, and to provide direct care services to residents. CNS-C's record included no hours of dementia care training. ULP-A ULP-A was hired on March 14, 2024, to provide direct care services to residents. ULP-A's EduCare (a training software program) included five hours and 45 minutes of dementia care training that was assigned by the licensee, however, was not completed. ULP-A's employee record included five hours of dementia care training completed by the licensee at an in-person training. ULP-G ULP-G was hired on February 25, 2024, to provide direct care services to residents. ULP-G's EduCare included five hours and 45 minutes of dementia care training that was assigned by the licensee, however, was not completed. ULP-G's employee record included five hours of dementia care training completed by the licensee at an in-person training.	01530		

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01530	Continued From page 23 On October 22, 2024, at 10:56 a.m., owner (O)-B stated ULP-A was a full-time employee. On October 22, 2024, at 11:14 a.m., O-B stated ULP-G was a full-time employee. On October 23, 2024, at 8:12 a.m., O-B stated the licensee provided three hours of dementia care training to all hired employees. On October 23, 2024, at 9:20 a.m., CNS-C stated when they began employment with the licensee, they reviewed the job position description and nursing policies via email and were orientated to the facility. CNS-C stated they were unable to remember the exact topics discussed when they were hired. The surveyor inquired how many hours of dementia care training were provided by the licensee to direct care employees. CNS-C stated employees received dementia care training through EduCare and they did not know how many hours employees received. On October 23, 2024, at 10:07 a.m., licensed assisted living director (LALD)-D stated employees received eight hours of dementia care training upon hire and then two hours annually. LALD-D stated care providers (a nonprofit membership association) provided the licensee with five tests related to dementia care however, the licensee covered three additional topics that were an additional three hours. The surveyor inquired if they had any documentation or course content of the other three hours the licensee provided. LALD-D stated they did not have documentation of the three additional hours of dementia that the licensee provided. The licensee's 5.03 Dementia Training policy	01530		

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01530	Continued From page 24 dated January 5, 2024, read, "Assisted Living licensed facilities: 1. Supervisors of direct care staff will complete eight (8) hours of initial training within 120 hours of the employment start date. 2. Direct care employees will complete eight (8) hours of initial training within 160 hours of the employment start date." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01610 SS=E	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan 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. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. This MN Requirement is not met as evidenced by: Based on interview and record review, the	01610		

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01610	Continued From page 25 licensee failed to a conduct a nursing assessment by a registered nurse (RN) of the physical and cognitive needs for two of four residents (R2, R4) on or before the admission date. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R2 R2 admitted to the licensee on June 1, 2024, and began receiving assisted living services. R2's diagnoses included type 2 diabetes mellitus (DM2), bipolar disorder, personality disorder, anxiety disorder, post-traumatic stress disorder (PTSD), major depressive disorder, and schizoaffective disorder (mental health condition that is marked by a mix of schizophrenia symptoms such as hallucinations and delusions, and mood disorder symptoms). R2's Service Plan (Waiver) - Addendum to Contract signed August 17, 2024, indicated R2 received assistance with appointments, housekeeping, laundry, behavior management, meals, medication administration, vital sign monitoring, safety checks, and shopping assistance.	01610		

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01610	Continued From page 26 R2's record included an Admission Assessment completed on June 2, 2024, one day after admission. R4 R4 admitted to the licensee on February 27, 2024, and began receiving assisted living services. R4's diagnoses included schizophrenia and mild cognitive impairment. R4's Service Plan (Waiver) - Addendum to Contract signed August 17, 2024, indicated R4 received assistance with bathing, dressing, grooming, housekeeping, laundry, behavior management, meals, vital sign monitoring, safety checks, socialization, toileting reminders, and transportation assistance. R4's record included an Admission Assessment completed on February 28, 2024, one day after admission. On October 23, 2024, at 9:23 a.m., clinical nurse supervisor (CNS)-C stated when there was a prospective resident, they would review the resident's medical record to determine if the licensee would be able to care for the resident. CNS-C stated they did not document the review for the resident because if a resident was not accepted it would create an issue in RTasks (a documenting software program). CNS-C stated if the licensee could meet the resident's needs and the resident admitted to the facility they would conduct an admission assessment within the first 24 hours. CNS-C stated R2's assessment was completed late because R2 was tiered when they admitted. CNS-C stated they completed a portion of the assessment on the day of admission,	01610		

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01610	Continued From page 27 however, RTasks did not save the date until the assessment was locked. CNS-C stated they did not remember why R4's assessment was locked the day after admission. The licensee's 6.01 Assessments, Reviews & Monitoring policy dated January 5, 2024, indicated the licensee would conduct a nursing assessment by a registered nurse (RN) of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the ate on which a prospective resident moves in, whichever is earlier. In addition, the initial nursing assessment must include all the elements of the uniform assessment tool as required, be in writing, dated, and signed by the RN who conducted the assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01610		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs	01620		

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01620	Continued From page 28 and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to complete an accurate assessment for one of four residents (R1). In addition, the licensee failed to ensure the registered nurse (RN) completed a 14-day reassessment for three of four residents (R2, R3, R4) and failed to ensure the registered nurse (RN) completed ongoing resident reassessments that did not exceed 90 days for three of four residents (R2, R3, R4). 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: ACCURATE ASSESSMENT R1 admitted to the licensee on November 29,	01620		

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01620	Continued From page 29 2023, and began receiving assisted living services. R1's diagnoses included conversion disorder (mental health issue disrupts how the brain works, leading to real, physical symptoms a person cannot control) with seizures, obsessive-compulsive disorder (OCD), chronic pain syndrome, chronic obstructive pulmonary disease (COPD), type 2 diabetes mellitus (DM2), bipolar disorder (mental health disorder characterized by extreme mood swings), borderline personality disorder, anxiety disorder, and depressive disorder. R1's Service Plan (Waiver) -Addendum to Contract signed August 22, 2024, indicated R1 received assistance with ambulation, bathing, dressing, grooming, housekeeping, laundry, behavior management, meals, safety checks, shopping assistance, socialization, and transportation. R1's last ongoing assessment was completed May 8, 2024. The assessment indicated the following about R2: -was independent with dressing; -was independent with ambulation; and -was independent with independent with grooming. R1's progress notes dated August 1, 2024, through October 16, 2024, included notes related to clinical nurse supervisor (CNS)-C's attempts to conduct an ongoing reassessment with R1. The surveyor received an email from the licensee dated September 23, 2024, which indicated the licensee contacted R1's case manager over R1's refusals to visit with the nurse.	01620		

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01620	Continued From page 30 On October 21, 2024, at 10:01 a.m., the surveyor observed a do not disturb sign on R1's door. On October 21, 2024, at 2:15 p.m., CNS-C stated R1 refused to complete any further assessment after May 2024. CNS-C stated R1discussed medical needs with their doctors and case manager and was in the process of relocating to independent living with six hours of personal care assistant (PCA) services. On October 22, 2024, at 7:42 a.m., the surveyor inquired with R1 about their assessment refusals. R1 stated, "there is no use, so I have not let them do it." R1 stated CNS-C checked in with them once a week to see how they were doing. R1 stated they were working on discharging from the facility to live in a home of their own with PCA services. On October 22, 2024, at 9:16 a.m., owner (O)-B stated R1 received assistance with the following upon their request: -hands on assistance for ambulation; -set up for bathing; and -hands on assistance for grooming when R1's hand had difficulty with movement. Licensed assisted living director (LALD)-D stated the assessment was incorrect because R1 did require assistance with the items listed on the service plan. On October 22, 2024, at 9:33 a.m., unlicensed personnel (ULP)-A stated R1 complained of weakness three to four times per week and would ask for assistance with showering, standing up from a seated position, combing hair, and pouring milk. ULP-A stated R1 was not consistent for asking for assistance and was independent many	01620		

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01620	Continued From page 31 days out of the week. On October 22, 2024, at 9:37 a.m., CNS-C stated when the last assessment was completed, R1 was working with their case manager to move out of the facility. CNS-C stated R1 was "mostly" independent however, required intermittent cares which is why they did not change the service plan after the assessment. 14-DAY/ONGOING ASSESSMENTS R2 R2 admitted to the licensee on June 1, 2024, and began receiving assisted living services. R2's diagnoses included DM2, bipolar disorder, personality disorder, anxiety disorder, post-traumatic stress disorder (PTSD), major depressive disorder, and schizoaffective disorder (mental health condition that is marked by a mix of schizophrenia symptoms such as hallucinations and delusions, and mood disorder symptoms). R2's Service Plan (Waiver) - Addendum to Contract signed August 17, 2024, indicated R2 received assistance with appointments, housekeeping, laundry, behavior management, meals, medication administration, vital sign monitoring, safety checks, and shopping assistance. R2's record included a 14-day assessment completed June 27, 2024, indicating 26 days passed since admission. In addition, R2's record contained an ongoing assessment completed on October 16, 2024, indicating 111 days passed between the June 27, 2024, assessment and October 16, 2024, assessment.	01620		

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01620	Continued From page 32 R3 R3 admitted on April 1, 2024, and began receiving assisted living services. R3's diagnoses included schizoaffective disorder, anxiety disorder, depression, bipolar disorder, and OCD. R3's Service Plan (Waiver) - Addendum to Contract signed August 17, 2024, indicated R3 received assistance with appointments, bathing reminder, housekeeping, laundry, behavior management, meals, medication administration, vital sign monitoring, safety check, and shopping assistance. R3's record included a 14-day assessment completed on April 23, 2024, indicating 22 days passed since admission. In addition, R3's record contained ongoing assessments completed on August 8, 2024, indicating 107 days passed between the April 23, 2024, assessment and August 8, 2024, assessment. R4 R4 admitted to the license on February 27, 2024, and began receiving assisted living services. R4's diagnoses included schizophrenia and mild cognitive impairment. R4's Service Plan (Waiver) - Addendum to Contract signed August 17, 2024, indicated R4 received assistance with bathing, dressing, grooming, housekeeping, laundry, behavior management, meals, vital sign monitoring, safety checks, socialization, toileting reminders, and transportation assistance. R4's record included a 14-day assessment	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36204	A. BUILDING: _____ B. WING _____	10/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARMSTRONG HOMES INC	7908 OREGON AVENUE NORTH BROOKLYN PARK, MN 55445

(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
01620	Continued From page 33 completed March 14, 2024, indicating 16 days passed since admission. In addition, R4's record included ongoing assessments completed June 27, 2024, and October 16, 2024, indicating 105 days passed between the March 14, 2024, assessment and June 27, 2024, assessment and 111 days passed between the June 27, 2024, assessment and October 16, 2024, assessment. On October 23, 2024, at 9:28 a.m., CNS-C stated assessment were completed within the first 24 hours of admission, on day 14, and every 90 days or with change of condition. CNS-C stated the surveyor may notice assessments one to two weeks late because the resident may have been at the doctor or sleeping when the nurse was trying to complete the assessment. CNS-C stated if a resident was tired, they would complete part of the assessment with the resident and then come back a different day to try to finish the assessment. The surveyor inquired if there was documentation of them attempting to complete the assessments timely. CNS-C stated no. The licensee's 6.01 Assessment, Reviews & Monitoring policy dated January 5, 2024, indicated resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		

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	36204	A. BUILDING: _____ B. WING _____	10/23/2024

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01750	Continued From page 34	01750		
01750 SS=E	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) specified in writing, specific instructions for medication administration for two of three 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R2 R2 admitted to the licensee on June 1, 2024, and began receiving assisted living services.	01750		

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	36204	A. BUILDING: _____ B. WING _____	10/23/2024

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01750	Continued From page 35 R2's diagnoses included type 2 diabetes mellitus (DM2), bipolar disorder, personality disorder, anxiety disorder, post-traumatic stress disorder (PTSD), major depressive disorder, and schizoaffective disorder (mental health condition that is marked by a mix of schizophrenia symptoms such as hallucinations and delusions, and mood disorder symptoms). R2's Service Plan (Waiver) - Addendum to Contract signed August 17, 2024, indicated R2 received assistance with appointments, housekeeping, laundry, behavior management, meals, medication administration, vital sign monitoring, safety checks, and shopping assistance. R2's medication administration record (MAR) dated October 24, 2024, included acetaminophen 500 milligrams (mg) give one up to two tablets (500 mg- 1000 mg) by mouth every six hours as needed (PRN) for pain. Maximum dose 4000 mg within 24 hours. The MAR indicated R2 received 500 mg 15 times and 1000 mg one time in time in the month of October. R2's MAR lacked specific instructions of when ULP should administer 500 mg verses 1000 mg of acetaminophen to R2. R2's Individualized Medication Management Plan dated October 21, 2024, lacked specific instructions related to administration of acetaminophen. In addition, R2 needed assistance to manage medication including set up, administration, and monitoring. R3 R3 admitted on April 1, 2024, and began receiving assisted living services.	01750		

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01750	Continued From page 36 R3's diagnoses included schizoaffective disorder, anxiety disorder, depression, bipolar disorder, and OCD. R3's Service Plan (Waiver) - Addendum to Contract signed August 17, 2024, indicated R3 received assistance with appointments, bathing reminder, housekeeping, laundry, behavior management, meals, medication administration, vital sign monitoring, safety check, and shopping assistance. R3's MAR dated October 2024 included Vicks DayQuil cough syrup 5 mg per 5 milliliters (ml) PRN. The surveyor inquired if there were more instructions for DayQuil in RTasks (a documenting software program). The surveyor observed additional instructions on the electronic medication administration record (EMAR) that included Vicks DayQuil cough syrup give 5 ml to 10 ml by mouth every six hours PRN for sore throat and cough. R3's individualized medication management plan dated August 8, 2024, lacked specific instructions related to administration of Vicks DayQuil cough syrup. On October 23, 2024, at 9:31 a.m., clinical nurse supervisor (CNS)-C stated R2 was alert and orientated and could tell the ULP how many tablets of acetaminophen they wanted. CNS-C stated they did not add specific instructions for R3 because R3 insurance would not cover the medication cost and the Vick DayQuil was never delivered to the facility. The licensee's 7.03 Medication Management Individualized Plan dated January 5, 2024, indicated the licensee would document specific	01750		

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01750	Continued From page 37 instruction related to the administration of medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
02310 SS=F	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 one resident (R1) who utilized 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) 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: R1 admitted to the licensee on November 29, 2023, and began receiving assisted living services.	02310		

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02310	Continued From page 38 R1's diagnoses included conversion disorder (mental health issue disrupts how the brain works, leading to real, physical symptoms a person cannot control) with seizures, obsessive-compulsive disorder (OCD), chronic pain syndrome, chronic obstructive pulmonary disease (COPD), type 2 diabetes mellitus (DM2), bipolar disorder (mental health disorder characterized by extreme mood swings), borderline personality disorder, anxiety disorder, and depressive disorder. R1's Service Plan (Waiver) -Addendum to Contract signed August 22, 2024, indicated R1 received assistance with ambulation, bathing, dressing, grooming, housekeeping, laundry, behavior management, meals, safety checks, shopping assistance, socialization, and transportation. On October 21, 2024, at 10:01 a.m., the surveyor observed a do not disturb sign on R1's door. On October 22, 2024, at 7:46 a.m., R1 reluctantly allowed the surveyor to enter their room. The surveyor observed a hospital bed that had bilateral (two sides) quarter rail hospital-style bed rails located at the head of the hospital bed. The bed rails were firmly attached to the bed. R1's ongoing assessments completed December 29, 2023, February 22, 2024, and May 8, 2024, indicated R1 had a hospital bed, mattress original to bed, and read, "Zone 5: Does the space between the split bed rails present a risk of head, neck, and chest entrapment (include the measurements in note field): Zone 5." The assessments contained no additional information about R1's bed rail. R1 had not had an ongoing	02310		

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02310	Continued From page 39 assessment since May 8, 2024. R1's record lacked current assessment of: - purpose and intention of the bed rail; - type of bed rail utilized; - documentation of R1's cognitive and physical status as they pertain to bed rails to determine the intended purpose for the bed rail and whether R1 was at a high risk for entrapment or falls; - documentation whether the bed rail has the effect of being an improper restraint; - documentation of bed rail measurements; - documentation of a physical inspection of the bed rail and mattress for areas of entrapment, stability, and correct installation; - documentation the licensee explained the risk versus benefits of the bed rail usage with R1 and/or R1's representative. R1's progress notes dated August 1, 2024, through October 16, 2024, included notes related to clinical nurse supervisor (CNS)-C's attempt to conduct an ongoing reassessment with R1. The surveyor received an email from the licensee dated September 23, 2024, indicating the licensee contacted R1's case manager over R1's refusals to visit with the nurse. On October 21, 2024, at 2:15 p.m., CNS-C stated R1 refused to complete any further assessment after May 2024. CNS-C stated R1discussed medical needs with doctors and case managers. CNS-C stated R1 was in the process of relocating to independent living with six hours of personal care assistant (PCA) services. On October 22, 2024, at 7:42 a.m., the surveyor inquired with R1 about their assessment refusals. R1 stated, "there is no use, so I have not let them	02310		

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02310	Continued From page 40 do it." R1 stated CNS-C checked in with them once a week to see how they were doing. R1 stated they were working on discharging from the facility to live in a home of their own with PCA services. On October 22, 2024, at 8:17 a.m., the surveyor inquired if R1 had a bed rail, and CNS-C stated they had not been in R1's room "for a long time". CNS-C stated R1 admitted with a bed rail however, R1 told them they were going to remove the bed rail. CNS-C stated they discussed the risks and benefits of a bed rail with R1 however, did not have documentation of the conversation. CNS-C stated they were unaware of the entrapment zone set by the FDA and the requirement to measure the zones. The Food and Drug Administration's (FDA), A Guide to Bed Safety, dated December 11, 2017, indicated following information: "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." The Minnesota Department of Health (MDH) document titled Resources & Frequently - Asked Questions (FAQs) dated October 15, 2024, read, "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	02310		

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02310	Continued From page 41 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. Additionally, the licensee must ensure the bed rail is securely attached to the bed frame per manufacturer guidelines. This includes consideration of any identified contradictions of use such as height/weight restrictions, age, mattress, bed frame set up, etc." In addition, the document read, "Even when bed rails are used according to manufacturer's guidelines, they can present a hazard. The licensee must ensure the resident and/or resident's responsible party has been educated on the risk for injury up to and including death due to entrapment." The document continued to read, "Best practice for documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail - Measurements - The resident's bed rail use/need assessment - Risk vs. benefits discussion (individualized to each resident's risks) - The resident's preferences - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements" In addition, the Minnesota Department of Health (MDH) document titled Resources & Frequently - Asked Questions (FAQs) dated October 15, 2024, read "If any aspect of patient care is not documented, it is viewed as not having been completed." The licensee's 6.28 Side Rail policy dated	02310		

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02310	Continued From page 42 January 6, 2024, indicated when the licensee was aware of a resident utilizing side rails on a bed, the licensee would assess the use, educate the resident, and when appropriate, the responsible person, regarding the risks and benefits of siderails, and verify that the side rail in use was of safe design and utilized consistent with the manufactures instructions. In addition, for the licensee to consider the bed rail safe it would be consistent with the FDA's 2006 dimensional measurement to reduce entrapment which indicated all zones would not exceed 4.75 inches. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	02310		

Minnesota Department of Health

3333 Division St #212
St. Cloud
320 223-7300

Type: Full
Date: *10/21/24*
Time: 10:30:00
Report: 1051241151

Food and Beverage Establishment Inspection Report

Location:

Armstrong Homes Inc
7908 Oregon Avenue North
Brooklyn Park, MN55445
Hennepin County, 27

Establishment Info:

ID #: 0038940
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6513543080
ID #:

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

No NEW orders were issued during this inspection.

Food and Equipment Temperatures

Process/Item: Upright Cooler
Temperature: 38 Degrees Fahrenheit - Location: MILK
Violation Issued: No

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

MET WITH NURSE EVALUATOR, ASHLEY CREWS.
DISCUSSED THE FOLLOWING WITH THE OWNER, MULUGHETA:

EMPLOYEE ILLNESS LOG
VOMIT CLEAN-UP PROCEDURE

THE KITCHEN HAS A NSF 184 DISHWASHER, POPCORN TEXTURE CEILING, LAMINATE COUNTERTOPS WITH HOLLOW BASES, AND VINYL WOODEN FLOORS.

Type: Full
Date: *10/21/24*
Time: 10:30:00
Report: 1051241151
Armstrong 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 1051241151 of 10/21/24.

Certified Food Protection Manager: Debasay Girmalul

Certification Number: FM110615 Expires: 12/11/24

Inspection report reviewed with person in charge and emailed.

Signed:_____
Mulugheta
Owner

Signed:_____
Kai Yang
Public Health Sanitarian 1
St. Cloud
320 640-3532
Kai.Yang@state.mn.us