Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF REMOVAL OF CONDITIONS ON PROVSIONAL LICENSE - LICENSE GRANTED

Electronic Delivery

January 9, 2023

Licensee
12778 183rd Court LLC
12778 183rd Court Northwest
Elk River, MN 55330

RE: Initial License Number 409180
Health Facility Identification Number (HFID) 39211
Project Number(s) SL39211015

Dear Licensee:

On December 5, 2023, The Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed September 6, 2023. The follow-up survey found the facility to be in substantial compliance. **Based on these findings, the condition(s) on the license were removed effective December 5, 2023.**

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

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,

Maria King, RN
Division Director

Minnesota Department of Health
Health Regulation Division

HHH

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF PROVISIONAL EXTENSION AND CONDITIONAL LICENSE

Electronically Delivered
October 10, 2023

Licensee
12778 183rd Court LLC
12778 183rd Court Northwest
Elk River, MN 55330

RE: Conditional License Number 409180
Health Facility Identification Number (HFID) 39211
Project Number(s) SL39211015

Dear Licensee:

The Minnesota Department of Health (MDH) completed an initial survey on September 6, 2023, for the purpose of assessing compliance with state licensing statutes and determine issuance of an initial license to the above-mentioned provider. Based on the survey results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G and Minnesota Food Code, Minnesota Rules Chapter 4626.

As a result, pursuant to Minn. Stat. § 144G.16, Subd. 3(b), MDH is extending your provisional license for 90-days and applying conditions necessary to bring the facility in substantial compliance. The conditional provisional license is due to expire on **January 8, 2024**.

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

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

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the provisional 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.

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

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

Please address your cover letter for reconsideration requests to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

CONDITIONAL PROVISIONAL LICENSE ISSUED:

MDH will issue 12778 183rd Court LLC a conditional provisional assisted living facility license for 90 calendar days from the date of this notice. At an unannounced point in time, within the 90 calendar days, MDH will conduct a follow-up survey, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the follow-up survey, MDH will determine if 12778 183rd Court LLC is in substantial compliance.

The following conditions apply on the provisional conditional assisted living facility license:

a. **No new substantiated maltreatment allegations:** If any new investigations begin in the conditional provisional license period, and the allegations are substantiated, MDH may pursue additional enforcement actions up to and including immediate temporary suspension and revocation of the provisional

license.

b. No new admissions: 12778 183rd Court LLC will not admit any new residents under its provisional conditional assisted living facility license until MDH removes the "no new admissions" condition. 12778 183rd Court LLC must provide the Department:

i. A list of the names and birthdates of any individuals 12778 183rd Court LLC is currently in the process of admitting. These individuals will be able to continue the admittance process.

ii. A list of all current residents by location including:
   1. Name and birthdate of each resident
   2. Physical location of each resident
   3. Current payment source for services
   4. If Elderly Waiver, the name and contact information of the care coordinator/case manager
   5. If the resident is not able to make informed decisions, the name of their representative and how to contact the representative

c. Consultant: 12778 183rd Court LLC will contract with an RN to provide consultation concerning all resident(s) to whom 12778 183rd Court LLC provides licensed assisted living services under the conditional provisional license. <u>The consultant must have access to all resident(s) receiving services from 12778 183rd Court LLC. The consultant will conduct initial and ongoing evaluations of the provider. Direct resident observation may be required based on the consultant's judgement or at the discretion of MDH</u>. The RN must not have any affiliation with 12778 183rd Court LLC and MDH must review the RN's credentials and approve the selection. 12778 183rd Court LLC is responsible for the expense of the contract with the RN. The main purpose of the consultant is to provide guidance to 12778 183rd Court LLC in an effort to help 12778 183rd Court LLC align their practices with the requirements of Minn. Stat. §§ 144G.01 – 144G.9999 and to provide oral and written reports to MDH noting progress toward substantial compliance and/or concerns about observations. 12778 183rd Court LLC will develop and implement policies, procedures, and processes specific to the offered services in accordance with the guidance provided by the consultant to ensure ongoing monitoring and substantial compliance with statutory requirements.

d. Reports: The RN consultant will provide MDH with regular reports at intervals specified by MDH. Reports will begin on a weekly basis until MDH notifies 12778 183rd Court LLC and the RN consultant about a change. Each report will be electronically submitted to Jessie Chenze, Survey Supervisor, State Evaluation Team, Health Regulation Division, at jessie.chenze@state.mn.us. Jessie Chenze can be reached at 218-332-5175 (office) with questions about reports. The

content of the reports will include information such as:

i. Progress towards correction of orders;
ii. Observations of staff delivering assisted living services and the level of competency observed;
iii. Conversations with residents and family members about satisfaction with assisted living services;
iv. Conversations with staff about their level of knowledge about the tasks they perform, the people they serve and the health professionals who delegate to them;
v. Overall impressions about the quality of the assisted living services delivered;
vi. Overall impressions about the dignity with which the residents and their family members are treated;
vii. Concerns; and
viii. Any other information requested by the Department or considered important by the RN consultant(s).

e. **Monitoring visits:** MDH may make unannounced monitoring visits to assess the progress of 12778 183rd Court LLC to correct the violations cited during the survey as well as to determine the overall practice of 12778 183rd Court LLC in meeting the needs of the people it serves. In addition, the Office of Ombudsman for Long-Term Care (OOLTC) may also make unannounced monitoring visits to determine the level of satisfaction of those people who receive licensed assisted living services. The OOLTC will share their findings with MDH.

f. **Follow-up survey:** At the time of the follow-up survey, MDH may pursue additional enforcement actions, up to and including immediate temporary suspension or revocation of the provisional license if MDH identifies any level 3 or 4 violations or widespread care related violations.

g. **Corrective Action Plan:** 12778 183rd Court LLC will develop and work within a corrective action plan (CAP). The CAP is a working document that includes at least the following information:
    i. A statement of the concern
    ii. A description of what will happen to correct the concern
    iii. A target date for when each correction will be complete
    iv. Who is responsible to make sure it happens
    v. Current status of correction work
    vi. Description of a plan to monitor and ensure ongoing substantial compliance for each corrected order

RESULTS OF FOLLOW-UP EVALUATION DURING THE CONDITIONAL PROVISONAL LICENSE PERIOD:
MDH will determine if 12778 183rd Court LLC is in substantial compliance based on the results of the follow-up survey. MDH will make this determination within the 90-day conditional provisional license

period. If MDH determines 12778 183rd Court LLC is in substantial compliance on the follow up survey, MDH will remove the conditions from 12778 183rd Court LLC's assisted living facility provisional license, and 12778 183rd Court LLC will correct violations identified during the survey to come into substantial compliance. If MDH determines 12778 183rd Court LLC is not in substantial compliance, MDH may take additional enforcement action against 12778 183rd Court LLC, including placement of additional conditions, issuing an extension to the conditional provisional license, or employ any of the enforcement tools listed in Minn. Stat. § 144G.20 up to and including immediate temporary suspension and revocation.

REQUEST FOR RECONSIDERATION:

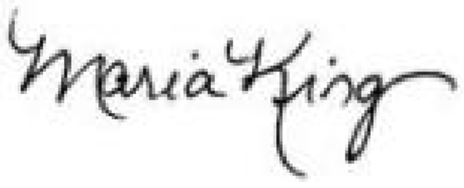
Pursuant to Minn. Stat. §144G.16, Subd. 4, the provisional licensee whose assisted living facility license has been denied, or extended with conditions disagrees with the action taken against the license under this section. The provisional licensee may request a reconsideration no later than 15 calendar days after provisional licensee receives notice of the action. The request for reconsideration should be addressed to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970
Health.HRD.Appeals@state.mn.us

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 Jessie Chenze directly at: 218-332-5175.

Sincerely,



Maria King, RN
Division Director

Minnesota Department of Health
Health Regulation Division

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39211	A. BUILDING: _____ B. WING _____	09/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
12778 183RD COURT LLC	12778 183RD COURT NW ELK RIVER, MN 55330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL#39211015-0 On September 5, 2023, through September 6, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were four (4) active residents whom were receiving services under the Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 115 SS=F	144G.10 Subd. 2 Licensure categories (a) The categories in this subdivision are established for assisted living facility licensure.	0 115		

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0 115	Continued From page 1 (1) The assisted living facility category is for assisted living facilities that only provide assisted living services. (2) The assisted living facility with dementia care category is for assisted living facilities that provide assisted living services and dementia care services. An assisted living facility with dementia care may also provide dementia care services in a secured dementia care unit. (b) An assisted living facility that has a secured dementia care unit must be licensed as an assisted living facility with dementia care. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the licensee only provided assisted living services in the facility. 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: During the entrance conference on September 5, 2023, at 10:15 a.m., clinical nurse supervisor (CNS)-A stated licensee's current census was three (3), however, four (4) residents were listed on the current resident roster provided by the licensee.	0 115		

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0 115	Continued From page 2 On September 5, 2023, at 11:30 a.m., the surveyor toured the facility with licensed assisted living director in residency (LALDIR)-D and noted three residents present with rooms setup in the facility. Licensee had a provisional assisted living license issued August 11, 2022, by the Minnesota Department of Health (MDH) posted at the front door entrance. On September 5, 2023, at 11:45 a.m., the surveyor asked CNS-A why CNS-A stated three residents resided in the building receiving services and four residents were listed on the current roster. CNS-A and licensed practical nurse (LPN)-C stated R1 had left the facility on August 25, 2023, on his own, had not returned and did not have plans to return. LPN-C stated the facility was providing medication set-up (placing ordered medications into a pill organizer by day and time) and delivering the medications to R1 at a new independent apartment located 45 miles away at the request of a payor agency. LPN-C stated the payor agency had requested the licensee hold R1's room in the event R1 would need to return. CNS-A stated R1 continued to receive medication setup and transportation services at his apartment location from licensee staff. On September 5, 2023, at 1:28 p.m., the surveyor interviewed LALDIR-D about the facility license. LALDIR stated she did not believe the facility had an active home care license and was unaware they were not allowed to provide home care services for R1 under the provisional assisted living license. LALDIR-D stated she had attempted to receive answers to licensing questions from vice president of operations (VP)-G, however, VP-G was not responding to LALDIR-D's phone calls or texts.	0 115		

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0 115	Continued From page 3 On September 19, 2023, at 10:23 a.m., the surveyor conducted a licensing record review of the Minnesota Department of Health (MDH) licensing records. On May 5, 2022, owner (O)-I applied for a provisional assisted living license and had a provisional assisted living license issued on August 11, 2022, and expired on August 10, 2023. Licensee lacked a comprehensive home care license to provide services in the community. Per 144G.08, Subd. 7. Assisted living facility means a facility that provides sleeping accommodations and assisted living services to one or more adults. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) Days	0 115		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This had the potential to affect all residents.	0 480		

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0 480	Continued From page 4 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated September 5, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 620 SS=D	144G.42 Subd. 6 (a) / 626.557, Subd. 3 Compliance with requirements for reporting ma (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. The requirement in Minnesota Statute section 626.557, Subd. 3 is: (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is	0 620		

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0 620	Continued From page 5 admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of	0 620		

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0 620	Continued From page 6 the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) for one of one resident (R1) who eloped, who had self-harm threats, and who had an unwitnessed fall with a head injury. 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: ELOPEMENT/SELF-HARM THREATS R1 admitted to the facility on April 24, 2023, for assisted living services. R1 left the facility on August 27, 2023, and did not return. R1's diagnoses included traumatic brain injury (TBI) and quadriplegia. R1's service plan dated April 24, 2023, indicated the resident received services including medication administration, treatments, catheter care, blood sugar monitoring, bathing assist, hygiene, grooming, dressing, incontinence care, food preparation, vital sign monitoring, behavior management, mobility assist, transfer assist with two staff and a Hoyer (mechanical lifting device utilizing a sling), transportation, housekeeping,	0 620		

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0 620	Continued From page 7 and laundry services. R1's Assessment dated June 30, 2023, indicated R1 had bilateral cochlear implants; English was his second language; had a history of seizures; a mood disorder; was feeling depressed and hopeless more than half of the time; was verbally aggressive; had angry outbursts; and frequently verbalized the desire to leave the facility. The assessment indicated R1 was unable to safely self-administer medications and had limited hand dexterity. R1's record lacked a behavioral management plan to provide staff with interventions and instructions for when R1 had verbal and physical outbursts or when he became aggressively demanding with staff. R1's Individual Abuse Prevention Plan (IAPP) dated May 8, 2023, indicated Spanish was R1's primary language and R1 could speak some English; an interpreter would be used as needed. R1 had a history of attempted self-transfers and falls. Staff were directed to provide supervised opportunities for R1 to be outside when appropriate. R1's IAPP indicated R1 was not an elopement risk. R1's progress notes indicated the following: - June 13, 2023, staff wrote, "R1 was swearing, yelling, screaming at staff, and throwing his shower chair repeatedly around the shower room. 911 was called for law enforcement assistance. R1 left out the front door without signing out where he was going, RN notified." - August 17, 2023, LPN-C wrote, "R1 had left the facility on August 13, 2023, for a period of five (5) hours and 911 was called due to the potential for	0 620		

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0 620	Continued From page 8 self-injury." On August 17, 2023, 911 was notified of R1's increased threats to staff of self-harm, with R1 telling staff he was, "going to the river to kill himself" and left the facility. On August 17, 2023, in the afternoon, LPN-C wrote R1 left the facility in the morning and returned three hours later, however, the electric wheelchair had run out of power at the bottom of the driveway and R1 was parked in the street and refused to transfer to a manual wheelchair. A local law enforcement officer checked on R1 in the early morning hours and told R1 he would check back with him at 11:00 a.m. - August 23, 2023, clinical nurse supervisor (CNS)-A wrote maintenance provided R1 transportation to physical therapy and upon return to facility R1 refused to exit the vehicle and threatened staff by raising his fists and threatening to hit staff. On September 5, 2023, at 11:55 a.m., the surveyor requested a copy of the report submitted to MAARC related to R1's self-harm threats and/or behaviors. CNS-A stated a MAARC report had not been completed or submitted. CNS-A didn't think a report would need to be filed since R1 left on his own. No MAARC report was provided for the June 13, 2023, August 17, 2023, or August 25, 2023, incidents. FALL WITH INJURY R1's record indicated R1 fell on June 17, 2023, resulted in a head injury, and required a three (3) day hospitalization. R1's progress notes dated June 17, 2023, written by an on-call licensed practical nurse (LPN)	0 620		

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0 620	Continued From page 9 indicated R1 was transported via ambulance to [hospital name] due to falling backwards in wheelchair and hitting his head while outside unattended. Reporter stated he had a large lump on his head. At 11:36 a.m., an LPN received an update from the hospital, [R1] was admitted to the trauma unit. Registered nurse (RN) updated via text. On June 18, 2023, an LPN wrote, received update [R1] was transferred from intensive care unit (ICU) to neuro unit with subdermal hematoma on right side of head and being treated for urinary tract infection (UTI) with intravenous (IV) antibiotics. On June 19, 2023, R1 was discharged back to the facility at 2:00 p.m. R1 was a Hoyer transfer with assist of three (3) staff to his power wheelchair. R1's Resident Incident Report, completed on June 17, 2023, at 8:35 a.m., written by LPN-C, and reviewed by CNS-A (undated by CNS-A), indicated R1 was up early and wanted to wait outside in his manual wheelchair at 8:00 a.m. for his ride. Staff was caring for other residents, stepped outside to dump garbage, and heard screaming for "help". Staff learned R1 tipped over at the end of driveway, trying to push himself over the curb. Staff ran hand under back of head palpated a "goose-egg" size lump. R1 remained immobilized until emergency medical services (EMS) arrived, at which time EMS applied a neck immobilizer. R1 was admitted to the trauma unit upon arrival to the hospital with a subdermal hematoma (brain bleed). On June 19, 2023, R1 was discharged back to the facility at 2:00 p.m. R1 was required a Hoyer transfer with assist of three (3) staff to his power wheelchair.	0 620		

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0 620	Continued From page 10 R1's progress notes dated June 20, 2023, included a registered nurse (RN) hospital follow up note written by CNS-A indicating R1 returned to the facility with "only small, raised area to back of head which R1 says still hurts a little if pressed on". No other areas of abrasion or injury. On September 6, 2023, at 2:52 p.m., CNS-A stated incident reports were completed by staff onsite and forwarded to RNs for review. CNS-A stated a MAARC report should be filed within 24 hours of knowledge of an event that could be any suspected abuse or maltreatment. Additionally, CNS-A stated, "he has his entourage, have you read his notes" and the facility didn't feel there was an elopement because R1 left on his own therefore a MAARC report was not submitted. The licensee's Vulnerable Adult Maltreatment - Prevention and Reporting policy, revised March 31, 2023, indicated consistent with the Minnesota Vulnerable Adults Act and Assisted Living licensure regulations, [licensee] sites prohibit the maltreatment of resident. To support this prohibition, [licensee] educates residents, family members, and team members (mandated reporters) about how to report suspected maltreatment internally and to MAARC. The policy provided did not address the investigative process by licensee or documentation of the investigative process. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		

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0 630	Continued From page 11	0 630		
0 630 SS=E	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure development of an individual abuse prevention plan with the required content for two of three residents (R1, 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, 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: R1 R1's diagnosis included a traumatic brain injury (TBI), a thoracic spinal cord injury resulting in	0 630		

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0 630	Continued From page 12 quadriplegia and neurogenic bowels. R1's service plan dated April 24, 2023, indicated the resident received services to include medication administration, treatments, catheter care, blood sugar monitoring, bathing assist, hygiene, grooming, dressing, incontinence care, food prep, vital sign monitoring, behavior management, mobility assist, transfer assist with two staff and a Hoyer (mechanical lifting device utilizing a sling), transportation, housekeeping and laundry services. R1's Individual Abuse Prevention Plan (IAPP) dated May 8, 2023, indicated Spanish was R1's primary language and R1 could speak some English, an interpreter would be used as needed. R1 had a history of attempted self-transfers, falls and staff were to provide supervised opportunities for R1 to be outside when appropriate and R1 was not an elopement risk. Additionally, R1's IAPP indicated he was not at risk for abusing other vulnerable adults, and not at risk for self-abuse. R1's progress notes dated June 4, 2023, through August 23, 2023, indicated the following: - June 13, 2023, staff wrote R1 was yelling, screaming and swearing, throwing a shower chair around the shower room and had aggressively pushed the shower chair into staff. Licensed practical nurse (LPN)-C instructed staff to call 911 for " an out of control and dangerous resident". Law enforcement arrived and intervened. Family consulted for insight and assistance to manage verbal and physical aggression. - June 14, 2023, staff wrote, LPN had been contacted due to R1 deliberately driving wheelchair into walls and swearing at staff. - June 24, 2023, LPN-C wrote, R1 was cursing	0 630		

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0 630	Continued From page 13 and name calling staff and refusing to calm door with other resident visitors present. - June 30, 2023, LPN-C wrote, staffed assisted R1 with a transfer into his wheelchair and resident started picking things up and throwing them around the room. Staff assisted putting his shoes on and resident left towards downtown (city name). Payor agency indicated R1 had just learned he was unable to return home due to family stating "he was too aggressive". - June 30, 2023, registered nurse (RN)-B wrote, resident does often make comments such as "I want to go home" or resists returning to facility when brought back. - July 10, 2023, LPN-C wrote, staff entered room and resident was in the bathroom doorway and had broke a jar and was swinging broken glass at her. R1 picked up a metal lamp and swung it hitting staff person's arm. 911 called and local law enforcement assisted staff. - July 19, 2023, LPN-C wrote, R1 was yelling and swearing and resident attempted to manually wheel his wheelchair into staff in an aggressive manner. Resident continued cursing and yelling at staff with visitors and other residents present before attempting to wheel self down an outdoor ramp. LPN-C wrote that R1 was slowed by staff due to R1's inability to operate new wheelchair and risk of injury. Additionally, LPN-C wrote R1 is unable to assess a situation for safety and when he is aggressive, it is not safe for staff to intervene putting him at risk for injury. DON (director of nursing) notified. - July 20, 2023, LPN-C wrote, R1 was verbally abusive to staff. LPN wrote when R1 was verbally aggressive LPN-C "did not feel comfortable getting within an arms distance of him".- July 24, 2023, an LPN wrote, resident had scratched a staffs car and was swearing, yelling, throwing things in room and had thrown a wet towel in	0 630		

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0 630	Continued From page 14 staffs face. A second staff member assisted and R1 threatened to punch him. "Staff was scared of resident and afraid to go into his room". 911 was called, law enforcement arrived and calmed resident. - July 30, 2023, on-call RN wrote, resident held his daughter hostage for about 30 minutes at the end of his family visit after church, then released her after on-call notified and threatened to call police. - August 17, 2023, LPN-C wrote, R1 was yelling, calling staff names, cursing and threatening self-harm. 911 was called to report threats of self-harm. LPN-C noted aggressive behaviors throwing coins at staff vehicles, ramming a staff's leg when staff member attempted to move the car. Law enforcement intervened. R1's individual abuse prevention plan did not accurately depict R1's vulnerabilities and risk of causing harm to others. R1's IAPP was not updated with interventions or statements of specific measures to be taken after each risk of R1 causing harm to others or self. R4 R4's diagnoses included above left-knee amputation, chronic prescription opiate use, rheumatoid arthritis and schizophrenia with psychosis. R4's service plan dated February 14, 2023, (R4 refused to sign), indicated the resident received services to include medication administration, treatments, bathing assist, hygiene, grooming, dressing, incontinence care, food prep, vital sign monitoring, behavior management, mobility assist, transfer assist, transportation, housekeeping, and laundry services.	0 630		

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0 630	Continued From page 15 R4's record failed to include an IAPP. On September 6, 2023, at 2:12 p.m., clinical nurse supervisor (CNS)-A stated IAPP's were created on admission and reviewed every 90 days when assessments were done. CNS-A verified R1's IAPP did not depict current and accurate risks or interventions and stated R4 did not have an IAPP, "I think sometimes things get lost". The licensee's Individual Abuse Prevention Plans policy dated April 5, 2023, indicated licensee would develop and implement an IAPP for each vulnerable adult and all residents in assisted living were categorically considered vulnerable adults. The plan would include and individualized review or assessment of the resident's susceptibility to be abused by another individual, resident's risk of abusing other vulnerable adults and specific measures to minimize the risk of abuse to that person and other vulnerable adults. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes;	0 780		

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0 780	Continued From page 16 (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 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 working and interconnected smoke alarms in the resident rooms and corridors throughout the facility. 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On a facility tour on September 6, 2023, at approximately 11:00 a.m. with maintenance (M)-H it was observed that smoke detectors were	0 780		

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0 780	Continued From page 17 installed throughout the facility, but the smoke alarm in the resident room to the left of the main floor bathroom did not operate upon activation of the test button. Smoke alarms are required to be maintained in operating condition according to manufactures installation instructions. This deficient finding was visually verified by M-H at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly 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) and was issued at a widespread scope (when problems are pervasive	0 800		

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0 800	Continued From page 18 or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On a facility tour on September 6, 2023, at approximately 11:00 a.m. with maintenance (M)-H it was observed that several electrical switches in the basement and on the main floor where broken. Electrical light switches are required to be maintained as installed at the time of construction approval. It was also observed the light at the bottom of the basement stairs was not working and the cover was missing. Electrical light fixtures are required to be maintained as installed at the time of construction approval. It was also observed that numbers identifying resident rooms were not provided. Room numbers identifying resident rooms are required to be maintained and used along with the fire safety and evacuation plan and floor plan. It was also observed that the sliding closet door had missing roller wheels and was off the track in the resident room near the bottom of the basement stairs. It was observed that the sidelight window glass in the front door assembly was broken. It was observed that an electrical outlet cover was missing on the outlet box in the soffit outside on the front wall. Electrical outlet covers are required to be maintained as installed and approved at the time of construction.	0 800		

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0 800	Continued From page 19 It was observed that a portable handicap accessible ramp unstable to walk on was used at the front door. The ramp was observed with no flat landing surface at the top and was not provided with handrails as required. The exterior means of egress from the main exit door is required to be maintained with approved stairs or ramps that lead to the public way. These deficient conditions were visually verified by M-H accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in	0 810		

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0 810	Continued From page 20 their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to maintain the facility's fire safety and evacuation plan with required elements. This had the potential to directly 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A record review of available documentation and interview were conducted on September 6, 2023, at approximately 10:15 a.m. of documents provided by maintenance (M)-H and licensed assisted living director in residence (LALDIR)-D on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility.	0 810		

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0 810	Continued From page 21 Record review of the available documentation indicated that the licensee did not provide number and location of resident rooms on the fire safety and evacuation floor plan. Resident room numbers are required to be included on the fire safety and evacuation floor plan for more accurate reference and communication of direction for evacuation. Record review of the available documentation indicated that the licensee included employee actions related to fire safety and evacuation but did not have specific employee actions for this specific facility and building located within the plan. Record review of the available documentation indicated that the licensee did not have fire protection procedures necessary for residents in the event of a fire or similar emergency located within the plan. Record review of the available documentation indicated the licensee did not have unique and unusual needs for individual resident movement or evacuation during a fire or similar emergency available with the fire safety and evacuation plan. Individual unique and unusual needs of each resident for evacuation during a fire or similar emergency is required to be available with the fire safety and evacuation plan in order to help communicate evacuation needs to staff and emergency personnel. Record review of the available documentation indicated that employees did not receive training upon initial hire and twice per year thereafter on the facility fire safety and evacuation plan. Facility fire safety and evacuation plan employee training	0 810		

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0 810	Continued From page 22 is required to be completed and documented separately from drills. Record review of the available documentation indicated that the licensee did not provided training once per year to residents who are capable of self-evacuation on the proper actions to be taken in the event of a fire regarding movement, evacuation, and relocation. Resident training on the fire safety and evacuation plan for the facility is required to be offered to the residents once annually. Record review of the available documentation indicated that evacuation drills had been conducted 8 times on the AM shift and 1 time on the PM shift. With the documentation provided no drills were conducted on the night shift. Evacuation drills for staff are required to be conducted every other month and twice per year per shift and completed and documented separately from employee training. All deficiencies were verified by M-H and LALDIR-D during the interview. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01620 SS=D	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.	01620		

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01620	Continued From page 23 (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive reassessment to include an assessment of current smoking status for one of one resident (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, 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: R4's diagnoses included above left-knee	01620		

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01620	Continued From page 24 amputation, chronic prescription opiate use, rheumatoid arthritis, and schizophrenia with psychosis. R4's service plan dated February 14, 2023, (R4 refused to sign), indicated the resident received services to include medication administration, treatments, bathing assist, hygiene, grooming, dressing, incontinence care, food prep, vital sign monitoring, behavior management, mobility assist, transfer assist, transportation, housekeeping, and laundry services. R4's Assessment dated June 30, 2023, indicated R4 experienced shortness of breath due to chronic obstructive pulmonary disease (COPD), had a history of encephalopathy, depression, poor judgement and insight, could be forgetful and confused at times. The assessment indicated R4 was resistive to cares, would self-isolate and withdraw, have angry outbursts and verbal aggression with staff and utilized a fentanyl intrathecal pain pump. R4's assessment did not address his smoking. On September 6, at 8:50 a.m., the surveyor observed R4 exit the basement slider door and light a cigarette. On September 6, 2023, at 8:55 a.m., licensed practical nurse (LPN)-C stated R4 smoked between five (5) and ten (10) times a day and all through the night. LPN-C stated R4's smoking was a concern because R4 had moderate contractures of his hands due to rheumatoid arthritis. On September 6, 2023, at 9:45 a.m., the surveyor with LPN-C attempted to interview R4 in his room located in the lower level of the facility. R4 stated	01620		

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01620	Continued From page 25 he keeps his lighters and cigarettes in his room and he smokes outside. R4 became agitated and demanded facility staff leave his room. LPN-C stated, "he probably thinks we are going to take away his cigarettes". LPN-C stated R4 has had an increase in irrational thinking and begun locking staff out of his room and won't allow anyone in at night. LPN-C was unsure if any staff had keys for R4's door. On September 6, 2023, at 3:04 p.m., the surveyor requested to review a smoking assessment for R4. Clinical nurse supervisor (CNS)-A stated she was not familiar with what a smoking assessment was and stated, "you won't find one of those". The surveyor educated CNS-A the uniform assessment tool included a smoking assessment area and CNS-A stated, "we don't use the whole uniform assessment tool, it's 23 pages long". The licensee's Assessment, Review and Monitoring policy dated April 4, 2023, indicated the initial nursing assessment or reassessment must include all the elements of the uniform assessment tool as required, conducted in person, be in writing, dated and signed by the registered nurse (RN) who conducted the assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility	01730		

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01730	Continued From page 26 must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management.	01730		

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01730	Continued From page 27 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and maintain a current individualized medication management plan to include all required content for one of three residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on September 5, 2023, at 10:00 a.m., clinical nurse supervisor (CNS)-A stated the licensee provided medication management services to all of the residents at the facility. R2's diagnosis included dementia. R2's service plan dated October 22, 2022, indicated R2 received medication management services. R2's electronic medication administration record (EMAR) dated September 2023, included amlodipine 10 milligrams (mg) daily, trazadone 50 mg daily, losartan potassium 100 mg daily, Zoloft 50 mg daily and acetaminophen 1000 mg three times daily. The EMAR did not include the treatment purpose for each medication.	01730		

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01730	Continued From page 28 On September 5, 2023, at 1:17 p.m., the surveyor observed unlicensed personnel (ULP)-E administer R2's afternoon medications. ULP-E washed hands, applied gloves, verified each medication against the EMAR and placed the pills into a medication crushing mechanism. ULP-E crushed the medications, added a tablespoon of pudding and mixed the combination. ULP-E went to R2 and assisted scooping spoonfuls of medicated pudding into R2's mouth. R2's Individualized Medication Management Plan dated October 22, 2022, directed R2's medications were to be administered whole. R2's record lacked evidence an individualized medication management plan had been developed that included the required content: - documentation of specific resident instructions relating to the administration of medications; - a current and updated medication management record; and - completion of medication reconciliation. On September 5, 2023, at 1:33 p.m., licensed practical nurse (LPN)-C verified R2's individualized medication management plan lacked a complete and accurate individual medication management plan. LPN-C stated hospice managed a lot of R2's medications. Licensee's Medication Management Individualized Plan policy dated June 6, 2022, indicated for each resident the facility would prepare and include a written statement of the medication management services to be provided to the resident based on a current resident assessment. The medication management record would be current and updated when there were any changes.	01730		

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01730	Continued From page 29 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01750 SS=F	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 prior to delegating the nursing task of medication administration, unlicensed personnel (ULP) were trained in the proper methods to perform the task or procedure for each resident and were able to demonstrate the ability to competently follow the procedure for one of one unlicensed personnel (ULP)-E. 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	01750		

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01750	Continued From page 30 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-E's employee record lacked evidence ULP-E demonstrated competency to the registered nurse (RN) for medication administration. ULP-E was hired on June 20, 2023, to provide assisted living services to licensee's residents. On September 5, 2023, at 1:17 p.m., the surveyor observed ULP-E administer R2's afternoon medications. ULP-E stated training was provided by licensed practical nurse (LPN)-C. R2's Electronic Medication Administration Record (EMAR) for August 2023 indicated ULP-E administered medications to R2 on August 5, 6, 11, 23, 24, 25, 2023. On September 5, 2023, at 2:40 p.m., the surveyor interviewed clinical nusre supervisor(CNS)-A and asked who was responsible for conducting staff training and competencies, including medications. CNS-A stated, "we have the certified medical assistants (CMAs) do delegated training. CMAs are doing initial med training, the delegated, pill identity, counting narcs, admin, insulin, inhalers, all aspects of medication administration. Then the LPNs are doing face-to-face during orientation for medication training. The LPN's sign off the medication training. I ask them to send the paperwork to me when their training is done". The surveyor asked CNS-A for clarification and reiterated the RNs were not doing any medication training, they were	01750		

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01750	Continued From page 31 reviewing completed training paperwork and signing it, CNS-A stated, "yes, that is correct". On September 5, 2023, at 2:45 p.m., CNS-A confirmed ULP-E's employee record indicated ULP-E and all staff administering medications had been trained and competency tested by a CMA and a LPN and lacked documentation of medication administration competency by a RN as required. The licensee's Medication Administration Training policy, dated March 2, 2023, indicated ULP would complete medication administration training with licensee's trainer and curriculum. Upon completion of training, trainee would observe assigned staff member at their assigned house passing medications for a minimum of two days. After two days of observation, trainee would pass medications with assistance of team lead/house nurse for a minimum of two days. After completing two days of medication administration with assistance, staff would be observed by the assisted living director in residency (LALDIR) and on the fourth day officially signed off by the director of nursing. During observation with LALDIR, it would be determined if more education was needed. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01750		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments	01880		

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01880	Continued From page 32 according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure one of one medication refrigerators maintained an acceptable temperature to ensure the medications were stored according to manufacturer's recommendations. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On September 5, 2023, at 2:50 p.m., the surveyor observed and reviewed a medication refrigerator with unlicensed personnel (ULP)-E. ULP-E confirmed the current temperature was 41 degrees Fahrenheit (F). ULP-E stated the medication refrigerator temperatures were monitored twice daily and recorded on a temperature log. Licensed practical nurse (LPN)-C stated the acceptable temperature range of 36-46 degrees F was printed on the top of the log sheet. The refrigerator contained the following medications: - two (2) unopened syringes of Orencia 125 milligram (mg)/milliliter (ml) for R4. On September 5, 2023, at 3:00 p.m., the medication refrigerator temperature log dated	01880		

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01880	Continued From page 33 August 2023 was provided and reviewed with LPN-C. The medication refrigerator temperature log had documentation completed 41 out of 62 possible recordings; two (2) out of the 62 recordings documented showed the temperature to be below 32 degrees F. LPN-C confirmed the temperatures should be recorded daily on the temperature log and this was not consistently being done. The manufacturer's instructions for Orencia pens dated March 2017, indicated unopened pens should be stored in the refrigerator between 36 to 46 degrees F and should not be frozen. The licensee's Medication Refrigerator policy, undated, noted the medication refrigerator must be checked twice daily, all medications in the refrigerator would be stored between 35 to 46 degrees F. and never expose refrigerated medications to freezing. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
03000 SS=D	626.557 Subd. 3 DO NOT USE / Timing of report (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the	03000		

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03000	Continued From page 34 individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c.	03000		

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03000	Continued From page 35 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) for one of one resident (R1) who eloped, who had self-harm threats, and who had an unwitnessed fall with a head injury. 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: ELOPEMENT/SELF-HARM THREATS R1 admitted to the facility on April 24, 2023, for assisted living services. R1 left the facility on August 27, 2023, and did not return. R1's diagnoses included traumatic brain injury (TBI) and quadriplegia. R1's service plan dated April 24, 2023, indicated the resident received services including medication administration, treatments, catheter care, blood sugar monitoring, bathing assist, hygiene, grooming, dressing, incontinence care, food preparation, vital sign monitoring, behavior management, mobility assist, transfer assist with two staff and a Hoyer (mechanical lifting device utilizing a sling), transportation, housekeeping, and laundry services.	03000		

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03000	Continued From page 36 R1's Assessment dated June 30, 2023, indicated R1 had bilateral cochlear implants; English was his second language; had a history of seizures; a mood disorder; was feeling depressed and hopeless more than half of the time; was verbally aggressive; had angry outbursts; and frequently verbalized the desire to leave the facility. The assessment indicated R1 was unable to safely self-administer medications and had limited hand dexterity. R1's record lacked a behavioral management plan to provide staff with interventions and instructions for when R1 had verbal and physical outbursts or when he became aggressively demanding with staff. R1's Individual Abuse Prevention Plan (IAPP) dated May 8, 2023, indicated Spanish was R1's primary language and R1 could speak some English; an interpreter would be used as needed. R1 had a history of attempted self-transfers and falls. Staff were directed to provide supervised opportunities for R1 to be outside when appropriate. R1's IAPP indicated R1 was not an elopement risk. R1's progress notes indicated the following: - June 13, 2023, staff wrote, "R1 was swearing, yelling, screaming at staff, and throwing his shower chair repeatedly around the shower room. 911 was called for law enforcement assistance. R1 left out the front door without signing out where he was going, RN notified." - August 17, 2023, LPN-C wrote, "R1 had left the facility on August 13, 2023, for a period of five (5) hours and 911 was called due to the potential for self-injury." On August 17, 2023, 911 was notified of R1's increased threats to staff of self-harm,	03000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39211	A. BUILDING: _____ B. WING _____	09/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
12778 183RD COURT LLC	12778 183RD COURT NW ELK RIVER, MN 55330

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03000	Continued From page 37 with R1 telling staff he was, "going to the river to kill himself" and left the facility. On August 17, 2023, in the afternoon, LPN-C wrote R1 left the facility in the morning and returned three hours later, however, the electric wheelchair had run out of power at the bottom of the driveway and R1 was parked in the street and refused to transfer to a manual wheelchair. A local law enforcement officer checked on R1 in the early morning hours and told R1 he would check back with him at 11:00 a.m. - August 23, 2023, clinical nurse supervisor (CNS)-A wrote maintenance provided R1 transportation to physical therapy and upon return to facility R1 refused to exit the vehicle and threatened staff by raising his fists and threatening to hit staff. On September 5, 2023, at 11:55 a.m., the surveyor requested a copy of the report submitted to MAARC related to R1's self-harm threats and/or behaviors. CNS-A stated a MAARC report had not been completed or submitted. CNS-A didn't think a report would need to be filed since R1 left on his own. No MAARC report was provided for the June 13, 2023, August 17, 2023, or August 25, 2023, incidents. FALL WITH INJURY R1's record indicated R1 fell on June 17, 2023, resulted in a head injury, and required a three (3) day hospitalization. R1's progress notes dated June 17, 2023, written by an on-call licensed practical nurse (LPN) indicated R1 was transported via ambulance to [hospital name] due to falling backwards in	03000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39211	A. BUILDING: _____ B. WING _____	09/06/2023

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03000	Continued From page 38 wheelchair and hitting his head while outside unattended. Reporter stated he had a large lump on his head. At 11:36 a.m., an LPN received an update from the hospital, [R1] was admitted to the trauma unit. Registered nurse (RN) updated via text. On June 18, 2023, an LPN wrote, received update [R1] was transferred from intensive care unit (ICU) to neuro unit with subdermal hematoma on right side of head and being treated for urinary tract infection (UTI) with intravenous (IV) antibiotics. On June 19, 2023, R1 was discharged back to the facility at 2:00 p.m. R1 was a Hoyer transfer with assist of three (3) staff to his power wheelchair. R1's Resident Incident Report, completed on June 17, 2023, at 8:35 a.m., written by LPN-C, and reviewed by CNS-A (undated by CNS-A), indicated R1 was up early and wanted to wait outside in his manual wheelchair at 8:00 a.m. for his ride. Staff was caring for other residents, stepped outside to dump garbage, and heard screaming for "help". Staff learned R1 tipped over at the end of driveway, trying to push himself over the curb. Staff ran hand under back of head palpated a "goose-egg" size lump. R1 remained immobilized until emergency medical services (EMS) arrived, at which time EMS applied a neck immobilizer. R1 was admitted to the trauma unit upon arrival to the hospital with a subdermal hematoma (brain bleed). On June 19, 2023, R1 was discharged back to the facility at 2:00 p.m. R1 was required a Hoyer transfer with assist of three (3) staff to his power wheelchair. R1's progress notes dated June 20, 2023,	03000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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03000	Continued From page 39 included a registered nurse (RN) hospital follow up note written by CNS-A indicating R1 returned to the facility with "only small, raised area to back of head which R1 says still hurts a little if pressed on". No other areas of abrasion or injury. On September 6, 2023, at 2:52 p.m., CNS-A stated incident reports were completed by staff onsite and forwarded to RNs for review. CNS-A stated a MAARC report should be filed within 24 hours of knowledge of an event that could be any suspected abuse or maltreatment. Additionally, CNS-A stated, "he has his entourage, have you read his notes" and the facility didn't feel there was an elopement because R1 left on his own therefore a MAARC report was not submitted. The licensee's Vulnerable Adult Maltreatment - Prevention and Reporting policy, revised March 31, 2023, indicated consistent with the Minnesota Vulnerable Adults Act and Assisted Living licensure regulations, [licensee] sites prohibit the maltreatment of resident. To support this prohibition, [licensee] educates residents, family members, and team members (mandated reporters) about how to report suspected maltreatment internally and to MAARC. The policy provided did not address the investigative process by licensee or documentation of the investigative process. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	03000		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility	03090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39211	A. BUILDING: _____ B. WING _____	09/06/2023

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03090	Continued From page 40 entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure signage was posted at the main entryway of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all residents, staff, and visitors of the licensee. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On September 5, 2023, at 10:00 a.m., the Minnesota Department of Health (MDH) surveyor entered the facility and did not observe electronic monitoring signs posted at the entrance doors. On September 5, 2023, at 11:30 a.m., the surveyor toured the facility with licensed assisted living director in residency (LALDIR)-D. LALDIR-A stated there were 4 active video cameras downstairs and 5 or 6 active video cameras upstairs. LALDIR-A stated she was aware of the specific statutory language required	03090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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03090	Continued From page 41 to be posted regarding electronic monitoring devices and confirmed licensee lacked required postings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	03090		

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

Type: Full
Date: *09/05/23*
Time: 11:10:26
Report: 7930231171

Food and Beverage Establishment Inspection Report

Location:
12778 183rd Court LLC
12778 183rd Court NW
Elk River, MN55330
Sherburne County, 71

Establishment Info:
ID #: 0041911
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/23

Operator:
12778 183rd Court LLC

Phone #:
ID #:

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

The following orders were issued during this inspection.

4-500 Equipment Maintenance and Operation

4-501.114C1 ***** Priority 1 *****

MN Rule 4626.0805C1 Provide and maintain an approved chlorine chemical sanitizer solution that has a minimum concentration of 50 ppm and a minimum temperature of 75 degrees F (24 degrees C) for water with a pH of 8 or less or a minimum temperature of 100 degrees F (38 degrees C) for water with a pH of 8.1 to 10.

PROVIDE CHLORINE OR QUATERNARY AMMONIA FOR SANITIZING SURFACES IN THE KITCHEN.

Comply By: 09/06/23

4-300 Equipment Numbers and Capacities

4-302.12B ***** Priority 2 *****

MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.

LIKE STATED ABOVE. AT TIME OF INSPECTION THERE WAS NOT A THERMOMETER ON SITE.

Comply By: 09/07/23

4-300 Equipment Numbers and Capacities

4-302.14 ***** Priority 2 *****

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

LIKE STATED ABOVE FOR CHLORINE OR QUATERNARY AMMONIA SANITIZER.

Comply By: 09/12/23

Type: Full
Date: *09/05/23*
Time: 11:10:26
Report: 7930231171
12778 183rd Court LLC

Food and Beverage Establishment Inspection Report

6-300 Physical Facility Numbers and Capacities

6-301.11 ***** Priority 2 *****

MN Rule 4626.1440 Provide an adequate supply of hand soap at each handwashing sink or group of 2 adjacent handwashing sinks.

PROVIDE SOAP AT THE HANDWASHING SINK IN THE KITCHEN. AT TIME OF INSPECTION IT WAS LOCATED AROUND THE CORNER OF THE CABINET.

Comply By: 09/05/23

2-100 Supervision

2-102.12AMN

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

LIKE STATED ABOVE. A COURSE NEEDS TO BE TAKEN AND PASSED AND SEND IN FOR STATE CERTIFICATE. APPLICATION EMAILED WITH REPORT.

Comply By: 10/05/23

Food and Equipment Temperatures

Process/Item: Upright Cooler
Temperature: 40 Degrees Fahrenheit - Location: MILK
Violation Issued: No

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

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 7930231171 of 09/05/23.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/__/_____

Inspection report reviewed with person in charge and emailed.

Signed:_____
Establishment Representative

Signed: Tina Remmele
Tina Remmele, R.S.
Environmental Health Specialist
St. Cloud District Office
320-223-7302
tina.remmele@state.mn.us

DEPARTMENT OF HEALTH

For Office Use Only:
Date Received: _____
Amount: $_____
Check #: _____
Approved: Yes_____ No_____

CFPM Initial Application

CERTIFIED FOOD PROTECTION MANAGER (CFPM)

Applicant information

Name _____
Last First Full middle name

Mailing address _____
Street City State ZIP County

Social security number * _____

* Required under Minnesota Statutes, section 270C.72, subdivision 4

Contact phone _____

Applicant email _____

Preferred method to receive renewal notifications

☐ Mailing address ☐ Applicant email

Employment information

Fill this in only if you work at a licensed establishment

Establishment name _____ License number (if known) _____

Work phone number _____

Establishment address _____
Street City State ZIP County

Type of establishment

☐ Bakery	☐ Grocery store	☐ Convenience store
☐ Bar	☐ Restaurant/fast food	☐ Camps
☐ Catering	☐ School	☐ Hotel/motel
☐ Day care	☐ Specialty food market	☐ Other _____

Approved exams

The applicant for initial certification as a CFPM shall complete a training course and pass an approved examination. The examination cannot be older than 6 months at the time of application. If the exam certificate is older than 6 months old, the applicant shall retake the initial course and pass the exam again before certification can be granted.

If you no longer have the exam certificate, first try to get a copy of the certificate or other proof of having passed the exam from the organization, company or school that conducted the course of the exam you took. If that does not work, contact the organization that provided the exam. Applicants for initial certification must provide proof they have passed an exam from an organization accredited by the ANSI-CFP Accreditation Program.

Individuals applying for CFPM in the State of Minnesota

The commissioner of health will use information provided in this application to determine if you meet the requirements for certification. Submitting false information is grounds for denying your application or suspending, revoking or taking other disciplinary action against your certificate, if issued. Failure to provide required information may delay the processing of your application and may be grounds for denying your application.

For information on licensing data see Minnesota Statutes, section 13.41.

Submit application

Before mailing, be sure to include the following

1. Completed and signed application form
2. Copy of your exam certificate
3. Check or money order (do not send cash) made payable to MDH for $35

Mail to

Minnesota Department of Health
Certified Food Protection Manager
Food, Pools, and Lodging Services Section
PO Box 64495
St. Paul, MN 55164-0495

Incomplete applications will be returned to the applicant.

Notice: The issuance of a dishonored check to this department will require a service charge of $30 per check as in Minnesota Statutes, section 604.113, subd.2 (a). Additional civil penalties may be imposed for non payment.

I certify that the information provided and submitted on this application is accurate and complete.

Signature _____ Date _____

Resources

Initial Minnesota CFPM
http://www.health.state.mn.us/divs/eh/food/cfm/howto.html#initialcfm

ANSI-CFP Accreditation Program
https://www.ansi.org/accreditation/credentialing/personnel-certification/food-protection-manager/ALLdirectoryListing?menuID=8&prgID=8&statusID=4

Minnesota Department of Health
Food, Pools, and Lodging Services Section
651-201-4500
health.foodlodging@state.mn.us
www.health.state.mn.us

December 2018
To obtain this information in a different format, call: 651-201-4500.

Employee Illness Log

- Employees are required to notify the person in charge (PIC) of their symptoms and pathogens that could cause foodborne illness.
- The PIC is required to record all reports of diarrhea or vomiting made by employees, and report the illness upon request.
- The PIC is required to notify the regulatory authority if any employees are known to be infected with ***Salmonella*, *Shigella*, Shiga toxin-producing *E. coli*, hepatitis A virus, norovirus, or another bacterial, viral or parasitic pathogen**.
- Minnesota Foodborne Illness Hotline: 1-877-Food-ILL (1-877-366-3455)

Report date	**Employee name**	**Vomiting***	**Diarrhea***	**Jaundice**	**Fever**	**Respiratory** (cough, sore throat, runny nose)	**Comments or additional symptoms**	**Date returned to work**	**Diagnosed with a pathogen?** (see list above)	**If diagnosed, 1-877-FOOD-ILL or local health agency contacted?**
6/12/2019	*John Doe*	*X*	*X*				*Sent home*	*6/15/2019*	*Yes – norovirus*	*Yes*

***Employees with diarrhea or vomiting CANNOT RETURN TO WORK for at LEAST 24 HOURS after symptoms end.**

Resources

Minnesota Department of Health Food Business Safety (www.health.state.mn.us/foodbizsafety)

Minnesota Department of Health
Food, Pools, and Lodging Services
PO Box 64975
St. Paul, MN 55164-0975
651-201-4500
health.foodlodging@state.mn.us
www.health.state.mn.us

Minnesota Department of Agriculture
Food and Feed Safety Division
625 Robert Street N
St. Paul, MN 55155-2538
651-201-6027
MDA.FFSD.Info@state.mn.us
www.mda.state.mn.us

MARCH 2019