



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

January 8, 2025

Licensee

Living Hope Homes- Peaceful Pines
14134 Rolling Oaks Circle Northeast
Prior Lake, MN 55372

RE: Project Number(s) SL40587015

Dear Licensee:

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.

The Minnesota Department of Health completed an initial survey on December 4, 2024, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

The Department of Health concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement.

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;

Level 3: a fine of \$3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.

Level 4: a fine of \$5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

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

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

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

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

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 MDH 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,

A handwritten signature in black ink, appearing to read "Jodi Johnson", with a long horizontal flourish extending to the right.

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

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40587	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/04/2024
NAME OF PROVIDER OR SUPPLIER LIVING HOPE HOMES PEACEFUL PINES			STREET ADDRESS, CITY, STATE, ZIP CODE 14134 ROLLING OAKS CIRCLE NE PRIOR LAKE, MN 55372		
(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 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: SL40587015 On December 2, 2024, through December 4, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were four residents; four receiving services under the provisional Assisted Living Facility 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 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.		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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0 480	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are	0 480			

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. 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 practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated December 2, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer	0 480			

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0 480	Continued From page 3 to the FBEIR for any compliance dates.	0 480			
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program to comply with accepted health care, medical, and nursing standards for infection control for two of two employees (unlicensed personnel (ULP)-C, ULP-D). This had the potential to affect all residents, visitors, and staff. 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).	0 510			

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0 510	Continued From page 4 The findings include: On December 3, 2024, at 8:04 a.m., the surveyor observed ULP-C pour R3's morning medications from bottles and bubble packs into ULP-C's hands and then place into a medication cup. Upon entered R3's bedroom, ULP-C applied gloves, exited R3's room to fill a glass, administered morning medications and applied a pain patch. ULP-C exited room, the surveyor did not observe ULP-C complete hand hygiene before or after glove use. On December 3, 2024, at 8:23 a.m., the surveyor observed ULP-C pour R2's morning medications from bottles and bubble packs into ULP-C's hands, place inside a medication cup and completed R2's morning medications. ULP-C applied gloves attached a needle to R2's insulin pen and dialed the insulin pen to 20 units before administering to R2. The surveyor did not observe ULP-C complete hand hygiene before or after glove use. On December 3, 2024, at 8:34 a.m., the surveyor observed ULP-C enter R4's bedroom and ULP-C applied gloves. ULP-C immediately left R4's room with gloves on to fill a glass. ULP-C removed gloves after re-entering the bedroom and placed a new pair of gloves on and administered R4's morning medications, and then removed gloves. The surveyor did not observe ULP-C complete hand hygiene before or after glove use. On December 3, 2024, at 11:34 a.m., the surveyor observed ULP-D prepping potatoes without wearing gloves. ULP-D did not use proper hygiene and infection control techniques with food preparation.	0 510			

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0 510	Continued From page 5 On December 3, 2024, at 11:45 a.m., clinical nurse supervisor (CNS)-B stated the ULPs are not trained to pour medications into their hands, but rather into a medication cup. In regard to glove use training, CNS-B trains ULPs when going dirty to clean wash or hand sanitize. But if in touch with body fluids or toileting, ULPs were trained to wash their hands. In addition, when going between gloves; use hand sanitizer before and after glove use. CNS-B stated when food prep is being completed, staff were trained and it was policy to wear gloves. The licensee's Gloves policy dated August 1, 2021, indicated gloves must be worn whenever there may be direct contact between any employee and contaminated objects or as instructed. In the procedure, it indicates to wash hands, apply gloves to both hands, remove contaminated materials, place materials in proper receptacle, removed gloves, dispose used gloves in the proper receptacle and rewashed hands. The licensee's Dining Room Service policy dated August 1, 2021, indicated staff will use proper hygiene and infection control techniques while serving and cleaning up. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510			
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	0 780			

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0 780	Continued From page 6 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; (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 comply with the current Minnesota Fire Code Provisions. 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 the potential to affect a large portion or all of the residents).	0 780			

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0 780	Continued From page 7 The findings include: During facility tour on December 4, 2024, from 8:55 a.m. through 9:16 a.m., with vice president of operations (VPO)-E, the surveyor observed the following. Resident room three, unoccupied, had a mounting bracket and wires for a smoke alarm on the ceiling, but the alarm had been removed. There was no smoke alarm present in resident room three. All sleeping rooms are required to have interconnected smoke alarms installed and maintained in operable condition. VPO-E was unsure why the detector had been removed but stated that a new one would be installed. The facility was equipped with an automatic fire sprinkler system. The surveyor asked for documentation of the annual fire sprinkler inspection. VPO-E provided an inspection report from 2021 that stated it was completed when the system was put into service. VPO-E could not provide documentation of a current inspection. The surveyor explained that annual inspection of the fire sprinkler system was required to ensure the system is in working condition. VPO-E verified the above findings while accompanying on the tour and stated they understood the requirements. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780			
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment	0 810			

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0 810	Continued From page 8 (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) staff 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) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff 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 interview and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and failed to conduct the required training and drills. This had the potential to directly affect all	0 810			

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0 810	Continued From page 9 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). The findings include: On December 4, 2024, at 9:16 a.m. vice president of operations (VPO)-E provided documentation on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee's FSEP, titled "4.7 Fire", dated August 1, 2021, failed to provide the following: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan was designed for a building with life safety systems such as smoke compartment doors, automatic dialing from the fire alarms, and fire alarm pull stations. The policies had not been updated to provide complete actions for employees to take in the event of a fire or similar emergency at this licensed facility which did not have life safety systems stated in the policy. The FSEP included standard resident evacuation procedures but failed to provide specific	0 810			

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0 810	Continued From page 10 procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include unique needs or evacuation status for each individual resident in writing and readily available for use in the event of a fire or similar emergency. The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. The evacuation map included in the FSEP was for a different facility. VPO-E stated they would make copies of the posted evacuation maps and include them in the FSEP. During an interview on December 4, 2024, at 9:58 a.m., the surveyor showed VPO-E where their policy listed the correct requirements. VPO-E stated they understood the areas of the policy that were incomplete and would work on bringing them into compliance. TRAINING Record review indicated the licensee failed to provide evacuation training based on the fire safety and evacuation plan to employees, at hire and twice per year. VPO-E provided documents of training provided on July 18, 2024, and November 12, 2024. The training documents had a sign-in for employees that attended The surveyor asked VPO-E if all employees had participated in the training. VPO-E stated that not all employees were present for the trainings. VPO-E stated they understood the requirement	0 810			

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NAME OF PROVIDER OR SUPPLIER LIVING HOPE HOMES PEACEFUL PINES			STREET ADDRESS, CITY, STATE, ZIP CODE 14134 ROLLING OAKS CIRCLE NE PRIOR LAKE, MN 55372		
(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
0 810	Continued From page 11 for employee training. DRILLS Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. Documents provided showed evacuation drills were conducted monthly, but all drills were conducted between 11:15 a.m. and 1:30 a.m. During an interview on December 4, 2024, at 9:58 a.m., the surveyor asked VPO-E to confirm that all work shifts had participated in evacuation drills. VPO-E stated that the times shown in the documentation were all during the day shift. VPO-E stated they understood the requirement of conducting at least two evacuation drills each year for each shift. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810			
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for	01640			

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01640	Continued From page 12 Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a written service plan was revised to reflect the current services provided for one of one resident (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: R2 was admitted March 4, 2024, with diagnoses that included heart failure and diabetes. On December 3, 2024, at 8:23 a.m., the surveyor observed unlicensed personnel (ULP)-C administer R2's morning medications. R2's service plan dated March 4, 2024, indicated R2 received assistance with bathing, bed mobility, bedmaking, behavior management,	01640			

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01640	Continued From page 13 housekeeping, dressing, grooming, laundry, meals, oxygen management, position/re-position, weekly vital signs, skin treatment, toileting, transfer assistance, wheelchair, and wound care. R2's service plan did not include compression stockings, continuous positive airway pressure/bilevel positive airway pressure (CPAP/BiPAP), elevate legs, medication administration, offload, glucose checks, oxygen checks, and wound care. On December 3, 2024, at 1:00 p.m. clinical nurse supervisor (CNS)-B stated R2's service plan did not reflect the current services provided to R2 as listed above. CNS-B stated R2 returned from a hospitalization on November 22, 2024, and R2's services updated. CNS-B stated the service plan did not get updated with the revisions and should have. The licensee's Service Plan Modifications policy dated August 1, 2021, indicated when a resident receives assisted living services and a change(s) to the service plan occurs, the service plan must be amended in writing and signed by the resident or the resident's designated representative. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640			
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a	01730			

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01730	Continued From page 14 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. This MN Requirement is not met as evidenced by:	01730			

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01730	Continued From page 15 Based on observation, interview, and record review, the licensee failed to include medication management services in the service plan for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 was admitted March 4, 2024, with diagnoses that included heart failure and diabetes. On December 3, 2024, at 8:23 a.m., the surveyor observed unlicensed personnel (ULP)-C administer R2's morning medications. R2's Individualized Medication Management Plan dated November 22, 2024, indicated services included medication administration. R2's record included a medication administration record including staff's initials of providing assistance with medication administration from November 1, 2024, through December 3, 2024. R2's Service Plan (waiver) dated March 4, 2024, did not include medication management services. On December 3, 2024, at 1:00 p.m., clinical nurse supervisor (CNS)-B stated the service plan did not include the service of medication administration, and further stated the service plan	01730			

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01730	Continued From page 16 would be revised. The licensee's Medication Management Individualized Plan policy, dated August 1, 2021, indicated that for each resident receiving medication management services, the facility will prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730			
01750 SS=D	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 one of one unlicensed personnel (ULP-C) followed medication procedures during insulin administration.	01750			

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01750	Continued From page 17 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 was admitted March 4, 2024, with diagnoses that included heart failure and diabetes. On December 3, 2024, at 8:23 a.m., the surveyor observed ULP-C administer R2's morning medications. R2's Individualized Medication Management Plan dated November 22, 2024, indicated services included medication administration. R2's provider note dated November 22, 2024, included an order for Lantus insulin 20 units once daily and Novolog insulin for pre-meal blood glucose results: 140-239 give 1 unit; 240-339 give 2 units; greater than or equal to 340 give 3 units. For bedtime blood glucose results: 200-299 give 1 unit; 300-399 give 2 units; for blood glucose greater than or equal 400 give 3 units. On December 3, 2024, at 8:23 a.m., ULP-C was observed preparing R2's opened Lantus SoloStar insulin pen for administration. ULP-C dialed the opened insulin pen to 20 units and ULP-C injected the insulin subcutaneously. On December 3, 2024, at 9:50 a.m., ULP-C was observed preparing R2's opened Novolog	01750			

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01750	Continued From page 18 Flexpen insulin pen for administration. ULP-dialed the insulin pen to 1 unit and ULP-C injected the insulin subcutaneously. ULP-C did not prime either Lantus insulin pen or Novolog Flexpen prior to dialing up the dosage for administration. On December 3, 2024, at 9:07 a.m., ULP-C stated she didn't prime insulin pens prior to dialing up the dosage, and further stated being unaware insulin pens should be primed each time other than when first opened. On December 3, 2024, at 11:45 a.m., clinical nurse supervisor (CNS)-B stated she trained staff to prime insulin pens prior to dialing up the dosage; however, CNS-B further stated she was not the nurse who trained ULP-C since the ULP was hired prior to CNS-B working for the licensee. The Lantus SoloStar pen patient information leaflet titled, How to use your Lantus SoloStar pen, dated 2022, indicated: -Attach the needle -Perform a safety test -Dial a test dose of 2 units -Hold pen with the needle pointing up and lightly tap the insulin reservoir so the air bubbles rise to the top of the needle. This will help you get the most accurate dose. -Press the injection button all the way in and check to see that insulin comes out of the needle. The dial will automatically go back to zero after you perform the test. -If no insulin comes out, repeat the test 2 more times. If there is still no insulin coming out, use a new needle and do the safety test again.	01750			

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01750	Continued From page 19 The patient information leaflet titled, Novolog Flexpen Instructions for Use, dated March 2023, indicated: -Attach the needle -Perform a safety test -Dial a test dose of 2 units -Hold your Novolog Flexpen with the needle pointing up. Tap the cartridge gently with your finger a few times to make sure any air bubbles collect at the top of the cartridge. -Keep the needle pointing upwards press the push-button all the way in. The dose selector returns to 0. -If you do not see a drop of insulin after 6 times, do not use the Novolog Flexpen and contact Norodisk. The licensee's Medication and Treatment orders - Receiving policy dated August 1, 2021, indicated all orders for medications and treatments must be current and consistent with the nursing assessment and content of medication orders must contain the name of the drug, dosage, frequency, route, indication and directions for use. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750			
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated	01890			

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01890	Continued From page 20 drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were not expired for the facility house supply. In addition, the licensee failed to ensure medications were maintained bearing the original prescription label for two of two residents (R3, R5) with medication cart reviewed. 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: R3's and R5's service plans dated February 19, 2024, and May 15, 2024, indicated R3 and R5 received services to include medication management. On December 2, 2024, at 2:40 p.m., the locked medication cart was reviewed with unlicensed personnel (ULP)-C. The following was observed and confirmed with ULP-C: Expired house supply medications: Lidoderm 5% patch had an expiration date of January 2015. No prescription label:	01890			

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01890	Continued From page 21 R3 -Excedrin Migraine relief; -Fiber Well gummies; -Joint and muscle support; -Vitamin D3 5,000 IU (international unit); -Claritin 10 mg (milligram); and -Melatonin 3 mg R5 -Melatonin 5 mg On December 2, 2024, at 2:47 p.m., clinical nurse supervisor (CNS)-B stated they would discard the expired medication, and would label the medications without a prescription label. The licensee's Medications - Prescription Drugs & Prohibition policy dated August 1, 2021, indicated the licensee receives a prescription drug, prior to being set up for immediate or later administration, the prescription drug must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written	01940			

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01940	Continued From page 22 statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to include treatment and therapy management services in the service plan for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a	01940			

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01940	Continued From page 23 limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 was admitted March 4, 2024, with diagnoses that included heart failure and diabetes. On December 3, 2024, at 9:46 a.m., the surveyor observed unlicensed personnel (ULP)-C complete R2's blood glucose test with a reading of 148. R2's Individualized Treatment and Therapy Plan dated December 3, 2024, indicated treatment services included continuous positive airway pressure/bilevel positive airway pressure (CPAP/BIPAP), daily weight, oxygen saturation and weekly vital signs. R2's record included a Service Recap Summary including staff's initials of providing assistance with therapies listed above from November 1, 2024, through December 3, 2024. R2's Service Plan (waiver) dated March 4, 2024, did not include treatment management services, as required. On December 3, 2024, at 1:00 p.m., clinical nurse supervisor (CNS)-B stated the service plan did not include the treatment and therapy services provided, and further stated the service plan would be revised. The licensee's Treatment and Therapy Management Plan policy dated August 1, 2021, indicated that for each resident receiving management of ordered or prescribed treatments	01940			

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01940	Continued From page 24 or therapy services, the facility will prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940			



Minnesota Department of Health
Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
6512014500

Type: Full
Date: 12/02/24
Time: 13:00:00
Report: 1047241337

Food and Beverage Establishment Inspection Report

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Location:

LIVING HOPE HOMES PEACEFUL PIN
14134 ROLLING OAKS CIRCLE NE
Prior Lake, MN55372
Scott County, 70

Establishment Info:

ID #: 0043825
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/24

Operator:

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.

4-700 Sanitizing Equipment and Utensils

4-703.11B

**** Priority 1 ****

MN Rule 4626.0905B Sanitize food contact surfaces of equipment and utensils after cleaning by using mechanical hot water operations that achieve a utensil surface temperature of 160 degrees F (71 degrees C) and are set up and maintained in accordance with the specifications of NSF International and the manufacturer's data plate.

KITCHEN DISHWASHER IS NOT CURRENTLY FUNCTIONAL. FACILITY CURRENTLY USING THREE BASIN MANUAL WASH/RINSE/SANITIZE PROCEDURE. A TICKET HAS BEEN SUBMITTED FOR MAINTENANCE TO FIX THE MACHINE

Comply By: 12/02/24

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.

NO THIN PROBE THERMOMETER AVAILABLE

Comply By: 12/09/24

Food and Equipment Temperatures

Process/Item: Cold Holding

Temperature: 39 Degrees Fahrenheit - Location: Refrigerator- deli meat

Violation Issued: No

Type: Full
Date: 12/02/24
Time: 13:00:00
Report: 1047241337

LIVING HOPE HOMES PEACEFUL PIN

Food and Beverage Establishment Inspection Report

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

The inspection was completed with the operator and reviewed with MDH nurse evaluator J. Panitzke.

The establishment has a residential kitchen and serves food that is prepared that day. The kitchen has wood floors, granite countertops, painted walls, and painted ceiling.

A multi basin sink is located in the kitchen. One basin is designated for handwashing. A residential dish machine is located in the kitchen.

Discussed hand washing, ware washing, staff illness policy, cleaning/sanitizing, serving highly susceptible populations, food handling procedures, temperature control, and final cook temperatures.

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 1047241337 of 12/02/24.

Certified Food Protection Manager Kelli Martese Dixon

Certification Number: FM120598 Expires: 11/06/26

Inspection report reviewed with person in charge and emailed.

Signed: _____

Kelli Dixon
LALD

Signed: _____

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