DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

March 23, 2022

Administrator
The Moments Of Lakeville
16258 Kenyon Avenue
Lakeville, MN 55044

RE: Project Number(s) SL33524015

Dear Administrator:

On March 3, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine correction of orders found on the evaluation completed on December 16, 2021. The follow-up evaluation determined your agency had not corrected all of the state licensing orders issued pursuant to the December 16, 2021 evaluation.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state licensing orders issued pursuant to the last evaluation completed on December 16, 2021, found not corrected at the time of the March 3, 2022, follow-up evaluation and/or subject to penalty assessment are as follows:

0680-Disaster Planning And Emergency Preparedness-144g.42 Subd. 10 = $500.00
0790-Fire Protection And Physical Environment-144g.45 Subd. 2 (a) (2)-(3) = $500.00
0800-Fire Protection And Physical Environment-144g.45 Subd. 2 (a) (4) = $500.00
0810-Fire Protection And Physical Environment-144g.45 Subd. 2 (b)-(f) = $500.00
1470-Content Of Required Orientation-144g.63 Subd. 2 = $500.00
2040-Fire Protection And Physical Environment-144g.81 Subdivision 1 = $500.00

The details of the violations noted at the time of this follow-up evaluation completed on March 3, 2022 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,000.00**. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), by the correction order date, the licensee must document in the provider's records any action taken to comply with the correction order by the correction order date. The commissioner may request a copy of this documentation and the assisted living facility's action to respond to the correction orders in future evaluations, upon a complaint investigation, and as otherwise needed.

IMPOSITION OF FINES:

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

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you have one opportunity to challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. This written request must be received by the Department of Health within 15 calendar days of the correction order receipt date. Please send your written request via email to the following:

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

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

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

We urge you to review these orders carefully. If you have questions, please contact Jessica Chenze at 651-508-2791.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Sincerely,

Jessica Chenze, Interim Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-508-2791 Fax: 651-215-9697

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33524	A. BUILDING: _____ B. WING _____	R 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MOMENTS OF LAKEVILLE	16258 KENYON AVENUE LAKEVILLE, MN 55044

(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 Initial comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDERS In accordance with Minnesota Statutes, section 144G.08 to 144G.95 these correction orders are issued pursuant to a survey. Determination of whether a violation has been 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: Project # SL33524015-1 On February 28, 2022, through March 3, 2022, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on December 16, 2021. At the time of the survey, there were 58 residents receiving services under the Assisted Living with Dementia Care license. As a result of the revisit, the following orders were reissued.	{0 000}	Minnesota Department of Health is documenting the State Licensing 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.	
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	{0 480}		

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{0 480}	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (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: No further action required.	{0 480}		
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and	{0 680}		

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{0 680}	Continued From page 2 (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to develop an all-hazards risk assessment emergency preparedness program and plan to include Appendix Z required elements. 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 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 the residents). The findings include: On February 28, 2022, at 2:00 p.m., an undated red binder titled "Fire/Weather/Elopement/Emergency Plan" identified by executive director (ED)-B as the licensee's emergency preparedness plan and Appendix Z was reviewed.	{0 680}		

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{0 680}	Continued From page 3 The licensee's plan lacked an all-hazards vulnerability assessment in addition to the following required content: - a comprehensive program to include infectious diseases; - a description of the population served by the licensee; - process for emergency preparedness (EP) collaboration with state and local EP officials/organizations; - procedure for tracking staff and residents; - subsistence needs for staff and residents during emergency situations; - development of policies/procedures to address: - evacuation plan; - shelter in place; - the medical record documentation system to preserve resident information; - use of volunteers; - emergency staff strategies; and - the facility's role in providing care and treatment at alternative sites. - a communication plan that included: - arrangement with other facilities; - names and contact information for resident physicians; - contact information for federal, state, tribal, local EP staff, or the ombudsman; - primary and alternative means for communicating with facility staff, or federal, state, regional and local emergency management agencies; - a method of sharing information and medical documentation for residents; - a means to provide information regarding the facility's needs, and its ability to provide assistance to include information about their occupancy; and -a method of sharing information from the	{0 680}		

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{0 680}	Continued From page 4 emergency plan with residents and their families. - EP training and testing program; - EP training program for staff (including documentation of training provided); and - EP testing/annual testing requirements. On March 1, 2022, at 12:00 p.m., ED-B indicated she was unaware the required components had not been completed but verified the above missing content. ED-B indicated she would be taking ownership to the plan to ensure it is completed correctly. No further information was provided.	{0 680}		
{0 790} SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to properly install and maintain fire extinguishers under the State Fire Code as required by MN Statute 144G.45 subd.2(a)(2). This had the potential to directly affect all residents and staff.	{0 790}		

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{0 790}	Continued From page 5	{0 790}		

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:

On March 3, 2022, between 1:10 p.m. to 2:00 p.m., survey staff toured the new part of the building with executive director (ED)-B. It was observed that the portable fire extinguisher located in the electrical room was placed on an equipment counter and not properly installed or secured.

On March 3, 2022, between 2:10 p.m. to 2:35 p.m., survey staff toured the existing part of the building under construction and remodeling with ED-B. It was observed the portable fire extinguishers located throughout the existing part of the facility under construction and remodeling were not maintained with monthly quick inspections.

On March 3, 2022, at approximately 3:15 p.m. ED-B acknowledged the findings during the exit interview and had already requested the construction manager to look into securing the extinguisher located in the electrical room.

No further information was provided.

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{0 800}	Continued From page 6	{0 800}		
{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 physical environment of the facility in a continuous state of good repair and operation to protect residents, staff, and visitors from potential harm. This has the potential to directly affect the health, safety, and well-being of all residents 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 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: On March 3, 2022, between 2:10 p.m. to 2:35 p.m., survey staff toured the existing part of the building under construction with Executive Director (ED)-B. While on tour, survey staff observed there was not a 2-hour fire separation in the link between the new and the remodeled parts of the building that was discussed at the	{0 800}		

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{0 800}	Continued From page 7 previous survey exit interview dated December 14, 2021, with Vice President of Operations (VPO)-A, to protect the new part of the building from the existing part under construction. Furthermore, survey staff observed fire protection sprinklers and smoke alarms were still covered with tape for painting at multiple locations throughout the existing building including resident rooms next to the fireplace on the west side, and the high ceiling in the corridor. The construction manager on site explained that the 2-hour fire separation had been removed recently and had a plan implemented from 6:00 a.m. to 6:00 p.m. to deactivate the fire and smoke detector systems and performed a watch during the work hours on site which was similar to a fire watch. Survey staff asked for a documented policy on the fire watch, and the construction manager stated that he will get it from his office. ED-B did not have additional comment on the fire watch. On March 3, 2022, at approximately 3:15 p.m. during the exit interview, survey staff explained to ED-B that because there was no fire separation to separate the new part of the building from the existing under construction, the new and remodel parts were considered as one building under one license and covering smoke alarms and fire sprinklers in the existing building posed concerns of the potential risks of fire safety and harm to resident's safety for the entire building. The ED-B acknowledged the finding and stated that she understood the facility (existing and new) was one building and will work with their construction company to obtain the fire watch policy. Survey staff agreed to allow the ED-B to submit additional information relating to their fire watch policy for further consideration by end of the date on March 4, 2022.	{0 800}		

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{0 800}	Continued From page 8 No further information was provided by end of the date on March 4, 2022.	{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 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.	{0 810}		

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{0 810}	Continued From page 9 This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to provide the required fire safety and evacuation drills, as well as the required documentation on employee training on fire safety and evacuation plans. This had the potential to directly affect the safety of all residents 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 had potential to affect a large portion or all of the residents). The findings include: On March 3, 2022, at approximately 2:35 p.m., survey staff received the fire safety and evacuation documentation, evacuation drill, and training documentation from the executive director (ED)-B for review, and the following were observed: - An insufficient number of evacuation drills were performed. Record review showed the last fire drill performed since the date of the last survey (December 14, 2021) was February 27, 2022, at 9:30 a.m. and the previous drill was September 15, 2021. The February 27, 2022, drill record lacked evacuation details. In addition, the facility's undated policy (page 6) documentation on drills has not been revised for compliance with minimum fire safety and evacuation drills since the documentation indicated drills must be	{0 810}		

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{0 810}	Continued From page 10 performed as semi-annual on all shifts, rather than the minimum required of twice per year per shift with at least one evacuation drill required every other month. -Lack of documentation on required training of employees on fire safety and evacuation plans. Documentation review showed that the licensee provided orientation training for new employees but failed to provide the updated documentation to substantiate that their employees will be trained twice a year on fire safety and evacuation plans. On March 3, 2022, at approximately 3:15 p.m. during the interview, ED-B acknowledged the findings. No further information was provided.	{0 810}		
{01470} SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;	{01470}		

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{01470}	Continued From page 11 (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions.	{01470}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MOMENTS OF LAKEVILLE	16258 KENYON AVENUE LAKEVILLE, MN 55044

(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
{01470}	Continued From page 12 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure three of five employees (unlicensed personnel (ULP)-N, director of nursing (DON)-C, and ULP-O) received orientation to assisted living facility licensing requirements and regulations before providing services with records 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 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: ULP-N ULP-N was hired on September 27, 2021, to provide assisted living with dementia care services. ULP-N's record lacked evidence of receiving orientation to assisted living with dementia care to include the following required content: - an overview of this chapter; - an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; - handling of emergencies and use of emergency services; - handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health	{01470}		

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{01470}	Continued From page 13	{01470}		

Facility Complaints;
- consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and
- a review of the types of assisted living services the employee will be providing and the facility's category of licensure.

DON-C
DON-C was hired on October 27, 2021, to provide assisted living with dementia care services and to provide supervision of staff.

DON-C's record lacked evidence of receiving orientation to assisted living with dementia care to include the following required content:
- an overview of this chapter;
- an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person;
- handling of emergencies and use of emergency services;
- handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints;
- consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and
- a review of the types of assisted living services the employee will be providing and the facility's

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{01470}	Continued From page 14 category of licensure. ULP-O ULP-O was hired on November 30, 2021, to provide assisted living with dementia care services. ULP-O's record lacked evidence of receiving orientation to assisted living with dementia care to include the following required content: - an overview of this chapter; - an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; - handling of emergencies and use of emergency services; - handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; - consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and - a review of the types of assisted living services the employee will be providing and the facility's category of licensure. On March 1, 2022, at 3:48 p.m., DON-C stated the onboarding of new employees had changed, and now all education must be completed prior to working. Employees hired prior to the licensing survey in December 2021, have been assigned the education but not all have completed it, including the above-named employees.	{01470}		

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{01470}	Continued From page 15 A policy for staff orientation to assisted living with dementia care was requested, but not provided. No further information was provided.	{01470}		
{01760} SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure PRN (as needed) medications had documentation of effectiveness after administration for two of four residents (R2, R4) with records reviewed. In addition, the licensee failed to ensure medications were administered as prescribed for one of three residents (R4) with records 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) and was issued at an	{01760}		

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{01760}	Continued From page 16 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 R2's service plan dated November 29, 2021, indicated R2 received services to include, but were not limited to medication administration. R2's physician orders dated November 29, 2021, identified gabapentin (anticonvulsant) 100 milligrams (mg) every 4 hours PRN for anxiety/restlessness/pain. R2's physician order dated February 11, 2022, identified morphine sulfate (for severe pain) 5 mg every 2 hours sublingual PRN for pain/SOB (shortness of breath) and lorazepam (antianxiety) 0.5 mg every 2 hours sublingual PRN for anxiety/agitation. R2's February 2022, medication administration record (MAR) identified the administration of the following: - February 10, 2022, at 5:16 a.m. gabapentin administered with no results documented. - February 15, 2022, at 5:26 a.m. morphine administered with no result documented. - February 16, 2022, at 5:41 a.m. morphine administered with no result documented. - February 16, 2022, at 11:33 a.m. morphine administered with no result documented. - February 18, 2022, at 1:03 a.m. lorazepam administered with no result documented. - February 18, 2022, at 1:03 a.m. morphine administered with no result documented. - February 18, 2022, at 10:23 a.m. morphine administered with no result documented.	{01760}		

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{01760}	Continued From page 17	{01760}		

R4
R4's service plan dated February 25, 2021, indicated R4 received services to include, but were not limited to medication administration.

R4's physician orders dated February 16, 2022, identified acetaminophen 1000 mg by mouth twice daily as needed for pain.

R4's February 2022, MAR identified the administration on the following dates and times:
- February 2, 2022, at 3:21 a.m. acetaminophen administered with no results documented.

On March 1, 2022, at 4:00 p.m., director of nursing (DON)-C verified the above findings. DON-C stated a follow up of whether the PRN medication was effective or not should have been documented on the MAR.

R4's physician orders dated February 16, 2022, identified polyethylene glycol (laxative) 3350 powder 17 grams in 4-8 ounces of liquid once daily and levothyroxine sodium (thyroid hormone) 137 micrograms (mcg) once daily.

On March 1, 2022, at 8:45 a.m., unlicensed personnel (ULP)-F was observed to prepare R4's medications. ULP-F opened a new container of R4's polyethylene glycol 3350 powder and after comparing the label with R4's MAR, proceeded to pour 7.5 milliliters (ml) of powder into a plastic measuring cup. ULP-F stated 7.5 ml was correct dosage when surveyor stopped ULP-F. ULP-F indicated she was unsure how to measure 17 grams, indicating normally there is a "scoop" to use that is labeled for 17 grams.

On March 1, 2022, at 8:54 a.m., R4 was sitting in the dining room and stated he had already eaten

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{01760}	Continued From page 18	{01760}		

his breakfast. ULP-F administered R4's medications, including levothyroxine sodium. After R4 had swallowed all medications, ULP-F was observed to document the administration on R4's MAR. ULP-F stated she was getting a "late" alert for the levothyroxine because it was ordered for 7:00 a.m. ULP-F indicated they had one hour on either side of the scheduled time to administer the medications and did not know why it was scheduled for 7:00 a.m., but always administered it with the other medications that were scheduled for 9:00 a.m. ULP-F was prompted to put a reason for the late administration in which she documented "given" on March 1, 2022, at 9:00 a.m.

On March 1, 2022, at 11:43 a.m., assistant director of nursing (ADON)-D verified the administration errors. ADON-D indicated universal scoops are in most residents' cupboards and would assist staff when administering polyethylene glycol. ADON-D further indicated nursing should review each residents MAR's and adjust the times of medications if able to combine and avoid future medication time errors.

The licensee's Administration and Documentation of PRN Medications policy dated November 15, 2017, included:
The RN (registered nurse) will document in the client's medication record/MAR, the PRN medication name, symptoms for which the PRN medication may be administered, dose, route, frequency, where it is stored, when the supervising nurse needs to be notified and whether staff must check back with the client following administration to determine whether PRN was effective, and if so, the length of time after administration when the staff must check

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{01760}	Continued From page 19 with the client. The licensee's Medication Administration policy revised June 22, 2020, included: Follow the "6 rights" - Right person - Right medication - Right time - Right route (i.e. by mouth, eye drops, to the skin) - Right dose (i.e. how many milligrams, drops) - Right chart/record to document that the medication was taken No further information was provided.	{01760}		
{02040} SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide the required documentation of the hazard vulnerability or safety risk assessment plan on and around the property. The hazards indicated on risk	{02040}		

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{02040}	Continued From page 20 assessment must be reviewed and mitigated to protect all residents from harm. This has the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the clients). The findings include: On March 3, 2022, at approximately 2:35 p.m., survey staff received the hazard vulnerability assessment plan (HVA) documentation from executive director (ED)-B for review. The HVA plan lacked mitigations to protect residents from harm from the identified hazards. Survey staff asked the ED-B if the licensee had assessed and developed mitigations for the hazards identified under the HVA plan, and the ED-B stated probably not as Vice President of Operations (VPO)-A was the person in charge of this information. On March 3, 2022, at approximately 3:15 p.m. during the interview, the ED-B acknowledged the finding. No further information was provided.	{02040}		
{03090} SS=C	144.6502, Subd. 8 Notice to Visitors Subd. 8.Notice to visitors. (a) A facility must post a sign at each facility entrance accessible to	{03090}		

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{03090}	Continued From page 21 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 the required notice was posted at the main entry way of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all current residents, staff and any visitors of the facility. This practice resulted in a level one violation (a violation that has not 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 potential to affect a large portion or all of the residents). The findings include: On February 28, 2022, at 3:00 p.m., an observation outside the main entrance, and just inside the main entrance, lacked the required posting for electronic monitoring devices. On March 1, 2022, at 3:00 p.m. executive director (ED)-B verified there was no posting available related to the statutory language for electronic monitoring at main entrance. ED-B located a sign with the statutory language in a desk and	{03090}		

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{03090}	Continued From page 22 indicated the posting had most likely been taken down as the frame did not match the others on the wall. No further information was provided.	{03090}		

Electronically Delivered
January 19, 2022

Administrator
The Moments Of Lakeville
16258 Kenyon Avenue
Lakeville, MN 55044

RE: Project Number(s) SL33524015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on December 16, 2021, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

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

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, no immediate fines are assessed.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up surveys. The licensee is not required to submit a plan of correction 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 issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the Department of Health within 15 calendar days of the correction order receipt date.

A state licensing 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 general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general 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

Free from Maltreatment reconsideration requests should addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,

Jodi Johnson, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jodi.johnson@state.mn.us
Telephone: 507-696-2437 Fax: 651-215-9697

HHH

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THE MOMENTS OF LAKEVILLE	16258 KENYON AVENUE LAKEVILLE, MN 55044

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0 000	Initial Comments 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 a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL33524015 On December 13, 2021, through December16, 2021, 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 51 residents receiving srevies under the provider's Assisted Living with Demenita Care license.	0 000	SL33524015 Minnesota Department of Health is documenting the State Licensing 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.	
0 110 SS=F	144G.10 Subdivision 1a Assisted living director license required	0 110		

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	33524	A. BUILDING: _____ B. WING _____	12/16/2021

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0 110	Continued From page 1 Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports was employed as required. This resulted in an immediate correction order on December 13, 2021, at approximately 2:50 p.m. 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: On December 13, 2021, at approximately 1:19 p.m. during entrance conference, the vice president of operations (VPO)-A stated he had applied for the licensed assisted living director (LALD) license, paid the fee, started the on-line classes, but was not done and did not have a mentor. VPO-A indicated the previous executive director (ED) had been the LALD, but left employment with the licensee in September 2021.	0 110		

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0 110	Continued From page 2 On December 13, 2021, at approximately 3:15 p.m. VPO-A printed off proof of the LALD application, which identified the following items were not yet completed on the applicant's checklist: - (prof) transcript; - practicum; - (ADL Course provider verification); - (NAB-Core); - (NAB RCAL); - STATE; - Resume; - Request employment verification; - Assisted Living Director Field Experience; - Coursework; and - all background checklist of requirements At this time, the VPO-A verified the LALD application was not completed. The licensee's 2.02 Personnel Files/Employee Records policy revised November 15, 2017, noted the employee records would include evidence of current professional licensure, registration, or certification. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate. VPO-A has sent regular updates to MDH since December 15, 2021, showing attempts of resolving the immediacy without success. The immediacy remains in effect.	0 110		
0 250 SS=F	144G.20 Subdivision 1. Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a	0 250		

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0 250	Continued From page 3 result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner;	0 250		

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0 250	Continued From page 4 (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to meet the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations, had developed and implemented current policies and procedures as required with records 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 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: During the entrance conference on December 14, 2021, at approximately 1:19 p.m. vice president of operations (VPO)-A confirmed he was responsible for and participated in the day-to-day operations. VPO-A stated they were familiar with the current Assisted Living with Dementia Care licensing rules and regulations.	0 250		

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0 250	Continued From page 5 The licensee attested they read and understood the Assisted Living with Dementia Care licensing statutes and rules upon application; however, the following orders were issued: The licensee failed to implement the following required policies and procedures: - orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; - orientation to and implementation of the assisted living bill of rights; - conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; and - medication and treatment management. Refer to licensing order at Statute 144G.10 Subd. 1. The licensee failed to ensure an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports was employed as required. Refer to licensing order at Statute 144G.42 Subd. 9. The licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included completion of a health history and symptom screening, and a two-step TST (tuberculin skin test) or other TB screening such as a blood test or chest x-ray, upon hire, for one of four employees licensed practical nurse (LPN)-I. In addition, the licensee failed to maintain documentation of a completed health history and symptom screening for two of three employees, director of nursing (DON)-C and unlicensed personnel (ULP)-E with records	0 250		

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0 250	Continued From page 6 reviewed. Refer to licensing order at Statute 144G.63, Subd. 1. The licensee failed to ensure orientation to assisted living licensing requirements and regulations was provided prior to providing services for one of one employee (unlicensed personnel (ULP)-E) with records reviewed. Refer to licensing order at Statute 144G.63, Subd. 2. The licensee failed to ensure employees received an orientation to assisted living facility licensing requirements and regulations before providing services for three of three employees (licensed practical nurse (LPN)-I, unlicensed personnel (ULP)-K, and director of nursing (DON)-C) with records reviewed. Refer to licensing order at Statute 144G.71, Subd. 8. The licensee failed to ensure as needed (PRN) medications had documentation of effectiveness after administration for one of four residents (R2) with records reviewed. In addition, the licensee failed to ensure medications were administered as prescribed for one of seven residents (R6) with records reviewed. Refer to licensing order at Statute 144G.71, Subd. 13. The licensee failed to ensure current written or electronically recorded prescriptions were obtained for all medications the provider had managed for one of nine residents (R6) with records reviewed. Refer to licensing order at Statute 144G.71, Subd. 20. The licensee failed to ensure time sensitive medications were dated when opened for one of one resident (R1) with insulin with records reviewed.	0 250		

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0 250	Continued From page 7 Refer to licensing order at Statute 144G.71, Subd. 22. The facility failed to document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition for one of one discharged resident (R5) with record review. Refer to licensing order at Statute 144G.72, Subd. 5. The licensee failed to ensure treatment or therapies were administered as directed, or to document the reason they were not administered, for one of three residents (R3) with records reviewed. Twenty-four (24) correction orders were issued, which indicated the licensee's understanding of the Minnesota statutes and Rules were limited or not evident for compliance with sections 144G.08 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 250		
0 430 SS=C	144G.40 Subd. 2 Uniform checklist disclosure of services (a) All assisted living facilities must provide to prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services	0 430		

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0 430	Continued From page 8 the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a). This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide a copy of the Uniform Disclosure of Assisted Living Services & Amenities (UDALSA) with the required content for four of four residents (R3, R4, R1, R2) with records reviewed. 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 potential to affect a large portion or all the residents). The findings include: R3, R4, R1, and R2's records lacked evidence of a UDALSA with the following required content: - a disclosure of the categories of assisted living licenses available and the category of license held by the facility; - a written checklist listing all services permitted	0 430		

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0 430	Continued From page 9 under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and - an oral explanation of all services offered under the contract. R3 R3 began receiving assisted living services on November 16, 2021. R3's Service Plan dated November 16, 2021, indicated R3 received services, which included bathing, grooming, dressing, treatments and medication administration. On December 14, 2021, at approximately 10:40 a.m., unlicensed personnel (ULP)-E was observed to put R3's call pendant necklace and socks on. R3's record lacked evidence the UDALSA was received by R3. R4 R4 began receiving services under the assisted living licensure on August 1, 2021. R4's Service Plan dated February 25, 2021, indicated R4 received services, which included bathing, grooming, dressing, treatments and medication administration. On December 14, 2021, at approximately 12:59 p.m., ULP-E was observed to empty R4's catheter leg bag. R4's record lacked evidence the UDALSA was	0 430		

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0 430	Continued From page 10 received by R4. R1 R1 began receiving assisted living services on July 7, 2020. R1's Service Plan dated July 7, 2020, indicated R1 received services, which included bathing, grooming, dressing, treatments and medication administration. On December 14, 2021, at 12:10 p.m. licensed practical nurse (LPN)-I was observed to check R1's blood glucose and administer insulin. R1's record lacked evidence the UDALSA was received by R1. R2 R2 began receiving assisted living services on November 29, 2021. R2's Service Plan dated November 28, 2021, indicated R2 received services, which included bathing, grooming, dressing, treatments and medication administration. On December 14, 2021, at 10:37 a.m. ULP-H was observed to provide redirection and ambulating with R2. R2's record lacked evidence the UDALSA was received by R2. On December 14, 2021, at 5:06 p.m. vice president of operations (VPO)-A stated the residents had received a statement of services, but the UDALSA had not been implemented yet;	0 430		

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0 430	Continued From page 11 therefore, none of the residents had received it. The licensee's policy was requested, but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 430		
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: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (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 51 residents residing at the facility.	0 480		

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0 480	Continued From page 12 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 the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated December 13, 2021, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 480		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on observation, interview and record	0 550		

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0 550	Continued From page 13	0 550		

review, the licensee lacked a posting of the grievance procedure to include the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. In addition, there was no evidence of the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, or any information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC). 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 tour of the facility on December 13, 2021, at approximately 2:05 p.m., it was observed the common areas lacked the required posting of the grievance procedure and information related to reporting suspected maltreatment to MAARC.

On December 13, 2021, at 3:19 p.m. the vice president of operations (VPO)-A stated he believed the postings were in place in the original portion of the building that was under renovation at the time of the survey. However, they had not been moved or put into place since residents were moved into the newly added part of the

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0 550	Continued From page 14 building. VPO-A confirmed no posting was available related to the statutory language for electronic monitoring. The licensee's "Complaint Policy and Procedure" dated November 17, 2017, identified "Each Resident and/or Resident representative, as appropriate, receives written information about how to file a complaint with the Offices of Health Facility Complaints and the Ombudsman for Long-Term Care, in accordance with the Home Care Bill of Rights. Each home care Resident also receives written information on [the licensee's] procedures for submitting a complaint about our services, including a statement that there will be no retaliation because of a complaint. Every effort is made to appropriately receive, investigate, and resolve complaints and to avoid any form of retaliation." The policy lacked information regarding posting for complaint procedure including contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, or any information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC). No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 550		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for	0 640		

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0 640	Continued From page 15 reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to support protection and safety by not posting information and phone numbers for reporting to the Minnesota Adult Abuse Reporting Center and failed to post the 911 emergency number in common areas and near telephones provided by the assisted living 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 a facility tour on December 13, 2021, at approximately 2:05 p.m. an observation of the common areas lacked information and phone numbers for reporting to the Minnesota Adult	0 640		

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0 640	Continued From page 16 Abuse Reporting Center and the 911 emergency number was not posted in common areas and near telephones provided by the assisted living facility. On December 13, 2021, at 3:19 p.m. the vice president of operations (VPO)-A stated he believed the postings were in place in the original portion of the building that was under renovation at the time of the survey; however, they had not been moved or put into place since residents were moved into the newly added part of the building. The licensee's Maltreatment - Communication, Prevention, and Reporting policy, dated November 15, 2017, identified "Consistent with the Minnesota Vulnerable Adults Act and Home Care Regulations, [the licensee] prohibits the maltreatment of home care residents. To support this prohibition, [the licensee] educates residents, family members, and staff about how to report suspected maltreatment, and provides individualized staff assessments, staff tools, and resources to minimize the risk of maltreatment of a resident." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 640		
0 660 SS=E	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by	0 660		

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0 660	Continued From page 17 the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included completion of a health history and symptom screening, and a two-step TST (tuberculin skin test) or other TB screening such as a blood test or chest x-ray, upon hire, for one of four employees (licensed practical nurse (LPN)-I). In addition the licensee failed to maintain documentation of a completed health history and symptom screening for two of three employees (director of nursing (DON)-C and unlicensed personnel (ULP)-E) with records 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	0 660		

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0 660	Continued From page 18 situation has occurred repeatedly; but is not found to be pervasive). The findings include: LPN-I LPN-I was hired February 2, 2021, to provide comprehensive home care services prior to the licensee's conversion to assisted living with dementia care license on August 1, 2021. On December 14, 2021, at 12:10 p.m. LPN-I was observed to administer insulin to R1. LPN-I's employee record contained a physician's report dated August 31, 2021, indicating a chest x-ray had been completed on August 27, 2020, and found no evidence of TB. LPN-I's record lacked evidence of a TB history and symptom screening or testing had been completed upon hire. DON-C DON-C was hired on December 13, 2021, to provide assisted living with dementia care services and to provide supervision of staff. DON-C's employee record contained a letter identifying a Quantiferon TB Gold blood test had been completed on October 12, 2021, with negative results; however, DON-C's employee record lacked evidence a TB history and symptom screen had been completed. ULP-E ULP-E was hired on November 30, 2021, to provide assisted living with dementia care services.	0 660		

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0 660	Continued From page 19 On December 14, 2021, at approximately 10:40 a.m., ULP-E was observed to put R3's call pendant necklace and socks on. On December 14, 2021, at approximately 12:59 p.m., ULP-E was observed to empty R4's catheter leg bag. ULP-E's employee record contained a letter identifying a Quantiferon TB Gold blood test had been completed on November 17, 2021, with negative results; however, ULP-E's employee record lacked evidence a TB history and symptom screen had been completed. On December 16, 2021, the human resources director (HRD)-M stated she was unaware of the missing symptom health screenings as staff were sent out for the testing. In addition, HRD-M believed the testing had to be within six months of hire, not 90 days as the CDC recommends. The licensee's Tuberculosis & Staff Screening policy dated November 1, 2016, identified "All home care staff whose essential job functions require work within the same air space of home care residents shall be screened and tested for tuberculosis." This was to occur "prior to the staff being exposed to residents". No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements:	0 680		

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0 680	Continued From page 20 (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to develop an all-hazards risk assessment emergency preparedness program and plan to include Appendix Z required elements. In addition, the licensee failed to post emergency exit diagrams and maintain testing and maintenance records for the emergency generator. 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	0 680		

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0 680	Continued From page 21 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 the residents). The findings include: On December 13, 2021, at approximately 1:19 p.m. during the entrance conference, the licensee's emergency preparedness plan and Appendix Z was requested. During a tour of the facility on December 13, 2021, at approximately 2:05 p.m. there was no observed signage posted or information regarding the licensee's emergency plan or emergency exit diagrams at the facility entrance, in the hallways, in the dining area or in the living areas. On December 14, 2021, at approximately 12:15 p.m. survey staff requested inspection, maintenance, and load test records for the emergency power generator. The vice president of operations (VPO)-A stated generators were tested automatically and clarified the facility had two generators, one new and one existing, but staff were not able to locate any documented records to show the inspection, maintenance, and load test of the emergency generators. The licensee failed to provide the minimum frequency of inspection, maintenance, and load test requirements for the emergency power generators as outlined under NFPA 110, (as referenced under the Code of Federal Regulations, title 42, section 483.73) to ensure proper performance of the generators as follow: -Records of weekly inspections of the generator systems.	0 680		

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0 680	Continued From page 22 -Records of monthly generator load tests. -Records of monthly transfer switch operation tests. On December 14, 2021, at approximately 4:00 p.m., vice president of operations (VPO)-A verified the findings and asked for more information about the emergency generator requirements to be sent to him. On December 16, 2021, at 9:00 a.m. VPO-A confirmed the licensee lacked a customized emergency preparedness plan and Appendix Z which included: - a written emergency disaster plan that contained a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; - post an emergency disaster plan prominently; - provide building emergency exit diagrams to all residents; - post emergency exit diagrams on each floor; - emergency and disaster training to all staff during the initial staff orientation; and - Appendix Z required elements No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone	0 730		

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0 730	Continued From page 23 number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and	0 730		

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0 730	Continued From page 24 (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to complete a discharge summary for one of one discharged resident (R5) with records 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 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: R5 began receiving assisted living services on October 12, 2021. R5's service plan dated October 9, 2021, indicated R5 received services, which included bathing, grooming, dressing, treatments and medication administration. R5's Progress Notes dated November 17, 2021, at 3:18 p.m. identified "Resident moved out today. Discharged with home care services in place - DON [director of nursing] coordinated with POA [power of attorney]/resident." R5's record lacked evidence a discharge summary had been completed.	0 730		

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0 730	Continued From page 25 On December 14, 2021, at 12:30 p.m. the assistant director of nursing (ADON)-D stated the "Progress Note" was the only discharge note completed, and she would look for a discharge summary. A policy regarding discharge of residents was requested, but none was provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to properly install and maintain fire extinguishers under the State Fire Code as required by MN Statute 144G.45 subd.2(a)(2). This had the potential to directly affect all residents and staff.	0 790		

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0 790	Continued From page 26 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: On December 14, 2021, between 10:30 a.m. to 12:30 p.m., survey staff toured the facility with the Vice President of Operations (VPO)-A. It was observed portable fire extinguishers throughout the facility were not tagged with monthly inspections as required (also known as "quick checks"). The VPO-A explained that the facility had only been officially opened for two months and the inspection records were kept in separate reports in their office. Further review of the "Fire Extinguisher Inspection Report" forms provided by the VPO-A, no inspection records were found. The forms were blank and had not been filled out. On December 14, 2021, at approximately 11:45 a.m., while on facility tour with the VPO-A, it was observed that the portable fire extinguishers located in the Sprinkler Riser Room and the Electrical Room in the lower level of the building were sitting on the floor and were not properly installed and secured. The VPO-A verified the finding at the time of the tour. On December 14, 2021, at approximately 4:30 p.m. the VPO-A acknowledged the findings during the exit interview. No further information was provided.	0 790		

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0 790	Continued From page 27 TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
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 physical environment of the facility in a continuous state of good repair and operation to protect residents, staff, and visitors from potential harm. This has the potential to directly affect the health, safety, and well-being of all residents 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 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: On December 14, 2021, at approximately 12:00 p.m., during facility tour with the Vice President of	0 800		

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0 800	Continued From page 28 Operations (VPO)-A, survey staff inquired about the building link between the two parts of the building (new and remodeled). VPO-A explained since the new part of the building was completed, all residents had been relocated there, and no residents were currently residing in the remodeled part of the building. The VPO-A further clarified the new part of the building had a capacity of 60 resident rooms and the remodeled part of the building had 30 bedrooms. As survey staff continued the tour with VPO-A (in the remodel part of the building), it was observed smoke alarms and sprinklers in the bedrooms and corridor were completely covered with plastic materials. Survey staff and the VPO-A further reviewed the building link in detail, and both agreed that there was not a fire separation in the link between the new and the remodeled parts of the building. Because there was no fire separation to separate the new part of the building from the existing, survey staff explained that the new and remodel parts were considered as one building under one license. Survey staff discussed concerns of the potential risks of fire safety and harm to resident's safety due to covered smoke alarms and sprinkler heads in the remodeled part of the building. On December 14, 2021, between 3:30 p.m. and 4:30 p.m., the VPO-A acknowledged the finding and stated that he understood they have one license and one building and will work with their construction company to have proper fire separation at the link while remodeling in the existing part of the building. The construction manager joined during the interview and reassured staff they will construct a minimum 2-hour fire separation at the link. The VPO-A further added that the remodel part of the building was scheduled to be completed by April 2022.	0 800		

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0 800	Continued From page 29 Survey staff explained that because the 30 rooms were under remodeling, the physical environment of those 30 rooms can't be surveyed and a follow-up will be necessary. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) 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 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.	0 810		

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0 810	Continued From page 30 (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 interview and record review, the facility failed to provide the required fire safety and evacuation drills, as well as the required documentation on employee training on fire safety and evacuation plans. This had the potential to directly affect the safety of all residents 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 had potential to affect a large portion or all of the residents). The findings include: On December 14, 2021, at approximately 12:30 p.m., staff received the requested fire safety and evacuation documentation, fire drills, and training documentation from the Vice President of Operations (VPO)-A for review. 1. Insufficient numbers of fire safety and evacuation drills were performed. The records provided showed that the drills were performed annually, September 15, 2021 (no time recorded), September 16, 2020 (11:30 a.m.), and December	0 810		

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0 810	Continued From page 31 19, 2019 (no time recorded). In addition, the facility's policy on fire drills indicated drills must be performed as semi-annual on all shifts, rather than the minimum required of twice per year per shift with at least one evacuation drill required every other month. 2. Lack of documentation on required training of employees on fire safety and evacuation plans. Documentation review showed that the licensee provided orientation training for new employees but failed to provide the documentation to substantiate that employees will be trained twice a year on fire safety and evacuation plans. Failure to provide training and drills can cause confusion and delay response time for evacuation of residents and employees. On December 14, 2021, at approximately 4:30 p.m. during the interview, VPO-A acknowledged the findings and re-assured that they will ensure employee training and fire drills policy will be revised, and training and drills will be performed as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 900 SS=F	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of:	0 900		

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0 900	Continued From page 32 (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop and execute a written assisted living contract prior to providing assisted living services for four of four residents (R4, R3, R1, R2) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 900		

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0 900	Continued From page 33	0 900		

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 the residents).

The findings include:

R4
R4 began receiving assisted living services on August 1, 2021.

R4's Service Plan dated February 25, 2021, indicated R4 received services, which included bathing, grooming, dressing, treatments and medication administration.

On December 14, 2021, at approximately 12:59 p.m. unlicensed personnel (ULP)-E was observed to empty R4's catheter leg bag.

R4's record lacked evidence an assisted living contract was received by R4.

R3
R3 began receiving assisted living services on November 16, 2021.

R3's Service Plan dated November 16, 2021, indicated R3 received services, which included bathing, grooming, dressing, treatments and medication administration.

On December 14, 2021, at approximately 10:40 a.m. ULP-E was observed to put R3's call pendant necklace and socks on.

R3's record lacked evidence an assisted living

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0 900	Continued From page 34 contract was received by R3. R1 R1 began receiving assisted living services on August 1, 2021. R1's Service Plan dated July 17, 2020, indicated R4 received services, which included bathing, grooming, dressing, treatments and medication administration. On December 14, 2021, at 12:10 p.m. licensed practical nurse (LPN)-I was observed to administer insulin to R1. R1's record lacked evidence an assisted living contract was received by R1. R2 R2 began receiving assisted living services on August 1, 2021. R2's Service Plan dated November 28, 2021, indicated R2 received services, which included bathing, grooming, dressing, treatments and medication administration. On December 14, 2021, at 10:37 a.m. ULP-H was observed to provide redirection and ambulating with R2. R2's record lacked evidence an assisted living contract was received by R2. On December 14, 2021, at 3:00 p.m. assistant director of nursing (ADON)-D verified none of the current residents had received an assisted living contract as the attorneys were reviewing the content prior to its implementation. ADON-D stated a copy of the new contract was in the	0 900		

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0 900	Continued From page 35 admit packet, but no residents had received or signed that one. The licensee's policy was requested, but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 900		
01460 SS=D	144G.63 Subdivision 1 Orientation of staff and supervisors All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure orientation to assisted living licensing requirements and regulations was provided prior to providing services for one of one employee (unlicensed personnel (ULP)-E) with records 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) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number	01460		

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01460	Continued From page 36 of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-E was hired on November 30, 2021, to provide assisted living with dementia care services. On December 14, 2021, at approximately 12:59 p.m. ULP-E was observed to empty R4's catheter leg bag. ULP-E's employee file lacked evidence orientation to assisted living licensing requirements and regulations had been provided. On December 16, 2021, at 9:45 a.m. human resources director (HRD)-L stated if the training information was not in the employee file, then it had not been completed. A policy for staff orientation to assisted living with dementia care was requested, but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01460		
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff	01470		

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01470	Continued From page 37 person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated	01470		

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01470	Continued From page 38 age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure three of three employees (licensed practical nurse (LPN)-I, unlicensed personnel (ULP)-K and director of nursing (DON)-C) received orientation to assisted living facility licensing requirements and regulations before providing services with records 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) 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: LPN-I LPN-I was hired February 2, 2021, to provide comprehensive home care services prior to the licensee's conversion to assisted living with dementia care license on August 1, 2021. On December 14, 2021, at 12:10 p.m. LPN-I was observed to administer insulin to R1.	01470		

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01470	Continued From page 39 LPN-I's record lacked evidence of receiving orientation to assisted living with dementia care to include the following required content: - an overview of this chapter; - an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; - handling of emergencies and use of emergency services; - handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; - consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and - a review of the types of assisted living services the employee will be providing and the facility's category of licensure. ULP-K ULP-K was hired December 21, 2017, to provide comprehensive home care services prior to the licensee's conversion to assisted living with dementia care license on August 1, 2021. On December 15, 2021, at 9:33 a.m. ULP-K was observed providing transfer assist, incontinent cares, and applying medicated cream and powders to R6. ULP-K's record lacked evidence of receiving orientation to assisted living with dementia care to include the following required content:	01470		

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01470	Continued From page 40 - an overview of this chapter; - an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; - handling of emergencies and use of emergency services; - handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; - consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and - a review of the types of assisted living services the employee will be providing and the facility's category of licensure. DON-C DON-C was hired on December 13, 2021, to provide assisted living with dementia care services and to provide supervision of staff. DON-C's record lacked evidence of receiving orientation to assisted living with dementia care to include the following required content: - an overview of this chapter; - an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; - handling of emergencies and use of emergency services; - handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health	01470		

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01470	Continued From page 41 Facility Complaints; - consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and - a review of the types of assisted living services the employee will be providing and the facility's category of licensure. On December 16, 2021, at 9:45 a.m. human resources director (HRD)-L stated if the training information was not in the employee file, then it had not been completed. HRD-L further stated, the facility had not completed training for assisted living with dementia care licensure since the conversion on August 1, 2021. A policy for staff orientation to assisted living with dementia care was requested, but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01470		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the	01760		

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01760	Continued From page 42 reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure as needed (PRN) medications had documentation of effectiveness after administration for one of four residents (R2) with records reviewed. In addition, the licensee failed to ensure medications were administered as prescribed for one of seven residents (R6) with records 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) 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 R2's physician order dated November 29, 2021, identified risperidone (for mental/mood disorder) 0.25 mg (milligrams) take at lunchtime and bedtime, in addition to the scheduled doses, can give 0.25 mg every 4 hours as needed for paranoia and agitation, with a max of 3 as needed doses in 24 hours. R2's December 2021, medication administration record (MAR) identified the administration on the	01760		

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	33524	A. BUILDING: _____ B. WING _____	12/16/2021

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01760	Continued From page 43 following dates and times: - December 4, 2021, at 9:18 a.m. with results noted as effective; - December 5, 2021, at 11:16 a.m. no results noted; - December 6, 2021, at 12:35 p.m. with results noted as effective; - December 7, 2021, at 8:13 a.m. no results noted; - December 9, 2021, at 8:14 a.m. no results noted; - December 11, 2021, at 1:28 p.m. no results noted; - December 12, 2021, at 12:10 p.m. no results noted; - December 13, 2021, at 1:02 p.m. no results noted. R2's progress note dated December 9, 2021, at 3:00 p.m. identified the as needed dose had been administered. Staff waited "about 45 minutes" for medication to take effect. Took five staff to provide personal cares as resident was very aggressive. Resident kicked, punched, shoved and "wrestled the staff down to the floor". On December 15, 2021, at 2:01 p.m. director of nursing (DON)-C and assistant director of nursing (ADON)-D verified the above findings. They stated only the nurses were to administer the as needed doses of risperidone. All of the as needed doses of risperidone should have documented follow up for effectiveness on the MAR, or in the progress notes. R6 R6's physician orders dated August 5, 2021, identified R6 was to receive nystatin (antifungal) cream 100000 unit/GM (gram) apply to groin area topically 2 times per day.	01760		

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01760	Continued From page 44 R6's December 2021, MAR identified nystatin cream 100000 unit/GM apply topically to groin twice daily. The medication had been signed as administered at 9:00 a.m. and 5:00 p.m. December 1, 2021, through December 15, 2021. On December 15, 2021, at 9:33 a.m. unlicensed personnel (ULP)-K and ULP-H transferred R6 into bed, changed incontinent brief, and ULP-K applied a powder to R6's groin. The powder was labeled "Antifungal Powder" and did not contain a pharmacy label. ULP-K stated hospice provided the powder. R6's MAR indicated nystatin cream 100000 unit/GM apply topically to groin twice daily. ULP-K stated the powder was used instead because it is "better". On December 15, 2021, at 11:10 a.m. ADON-D was unaware the staff were using "Antifungal Powder" for R6 instead of the nystatin as ordered. She stated the order for R6 is nystatin cream and the staff should follow the physician's orders. The licensee's Medication Administration policy dated November 15, 2017, identified "Using the Medication Administration Record (MAR) licensed nurse may administer medications if: - The medications have prescriber's orders on file - Charting on the resident's medication sheet will serve as notification" "Follow the "6 rights" - Right person - Right medication - Right time - Right route (i.e. by mouth, eye drops, to the skin) - Right dose (i.e. how many milligrams, drops) - Right chart/record to document that the medication was taken"	01760		

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01760	Continued From page 45 "Always know the medications that you are giving, what effects they have and what the side effects are. If you are not sure about any medication, check your medication reference manual." Staff were to "Compare the information on the MAR with the label on the medication container." "The following information should be in all places: - Individual resident's name - Name of medication - Strength and dosage of medication - Route - Time that the medication should be given - Any special instructions" "The directions on the label and the MAR should be the same." The policy lacked any information pertaining to administration of as needed medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure current written or electronically recorded prescriptions were obtained for all medications the provider had managed for one of nine residents (R6) with records reviewed.	01820		

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01820	Continued From page 46 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 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: R6 On December 15, 2021, at 9:33 a.m. unlicensed personnel (ULP)-K and ULP-H transferred R6 into bed, changed incontinent brief, and ULP-K applied "Calazime Skin Protectant" to R6's coccyx and gluteal areas. The Calazime did not contain a pharmacy label and was not marked with R6's name. ULP-K stated hospice provided the Calazime. R6's Medication Administration Record (MAR) did not include the Calazime skin protectant. ULP-K verified it was not on the MAR, but it should be. ULP-K further stated she knew she was supposed to use it, because it was with the supplies in her room . R6's physician orders lacked evidence of an order for Calazime Skin Protectant. On December 15, 2021, at 11:10 a.m. assistant director of nursing (ADON)-D was unaware the staff were using Calazime Skin Protectant on R6, and stated the staff should follow the physician's orders. The licensee's Medication Administration policy dated November 15, 2017, identified "Using the Medication Administration Record (MAR) licensed nurse may administer medications if:	01820		

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01820	Continued From page 47 - The medications have prescriber's orders on file - Charting on the resident's medication sheet will serve as notification" "Follow the "6 rights" - Right person - Right medication - Right time - Right route (i.e. by mouth, eye drops, to the skin) - Right dose (i.e. how many milligrams, drops) - Right chart/record to document that the medication was taken" "Always know the medications that you are giving, what effects they have and what the side effects are. If you are not sure about any medication, check your medication reference manual." Staff were to "Compare the information on the MAR with the label on the medication container." "The following information should be in all places: - Individual resident's name - Name of medication - Strength and dosage of medication - Route - Time that the medication should be given - Any special instructions" "The directions on the label and the MAR should be the same." The policy lacked any information pertaining to administration of as needed medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in	01890		

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01890	Continued From page 48 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. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure time sensitive medications were dated when opened for one of one resident (R1) with insulin with records 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 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: On December 14, 2021, at 12:10 p.m., licensed practical nurse (LPN)-I was observed administering insulin to R1. R1 had a Novolog Flexpen insulin pen which lacked the date the pen had been opened, and when the pen would expire. LPN-I confirmed there was no open date or expiration date noted on the pen. She stated the pens were to be dated when opened by the nurse who opened them. LPN-I further stated the pen was used until empty and was unaware of the manufacturer recommendations regarding disposal 28 days after opening. On December 14, 2021, at 12:25 p.m. assistant	01890		

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01890	Continued From page 49 director of nursing (ADON)-D stated staff were to place an open date on the insulin pen when opening a new pen. Insulin should be discarded after 28 days per manufacturer recommendations. She stated the information for manufacturer recommendations was in a pharmacy resource book in the nursing office, titled "Medication Storage Guidelines for Commonly Used Medications", and staff were to follow that protocol. The licensee's "Medication Storage Guidelines for Commonly Used Medications" policy identified Novolog was to be discarded 28 days after opening. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the	01910		

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01910	Continued From page 50 medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition for one of one discharged resident (R5) with record review. 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: R5 began receiving assisted living services on October 12, 2021. R5's Service Plan dated October 9, 2021, indicated R5 received services, which included bathing, grooming, dressing, treatments and medication administration. R5's Progress Notes, dated November 17, 2021, at 3:18 p.m. identified "Resident moved out today.	01910		

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01910	Continued From page 51 Discharged with home care services in place - DON [director of nursing] coordinated with POA [power of attorney]/resident." R5's record lacked evidence of a disposition of medications. On December 14, 2021, at 12:30 p.m. the assistant director of nursing (ADON)-D stated she would look for a disposition of medications; however, no disposition of medications was provided by survey exit. A policy regarding resident discharge was requested, but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01910		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	01960		

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01960	Continued From page 52 review, the licensee failed to ensure treatment or therapies were administered as directed, or to document the reason they were not administered, for one of three residents (R3) with records 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 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: On December 14, 2021, at approximately 10:40 a.m. R3 was sitting in a wheelchair next to her bed. A knee brace was observed laying on the back of R3's recliner chair. Unlicensed personnel (ULP)-E was observed to put R3's call pendant necklace and socks on. Several scabs were noted on R3's lower extremities and dried blood was observed on the bedding. R3 stated she is a "picker" and picks the scabs on her legs. ULP-E verified she did not have any treatments to complete to R3's skin, and indicated R3 no longer wore a leg brace. R3's diagnoses included, but were not limited to, dementia and trochanteric fracture of left femur (a break in the upper part of the femur bone). R3's Service Plan dated November 16, 2021, indicated R3 received services, which included bathing, grooming, dressing, treatments per current therapy and physician orders, and medication administration.	01960		

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01960	Continued From page 53 R3's prescriber orders dated November 15, 2021, included the following orders: -cast care 3 (three) times per day during day, evening, and night: keep clean, dry, and intact; do not put anything down cast; cover with bag during showers to ensure it stays dry. -Tx (treatment) to RLE (right lower extremity) abrasions 1 (one) time per day during the day: cleanse all open areas with NS (normal saline), pat dry, apply skin prep to peri wounds, cover with non-adherent dressing and secure with Kerlix and tape. -skin prep to 4th L (left) toe d/t (due to) cast sitting on skin 1 (one) time per day during day. R3's prescriber orders dated November 16, 2021, included an order for brace when up, PRN (as needed) when in bed. R3's eMAR (electronic medication administration record) dated December 1, 2021, through 10:48 a.m. December 14, 2021, included cast care three times per day; however, it lacked documentation R3 received cast care 32 of the 40 opportunities. R3's eMAR dated December 1, 2021, through 10:48 a.m. December 14, 2021, included an order for RLE abrasion care one time per day; however, it lacked documentation R3 received RLE abrasion care 11 of the 14 opportunities. R3's eMAR dated December 1, 2021, through 10:48 a.m. December 14, 2021, included an order for skin prep to 4th left toe one time per day; however, it lacked documentation R3 received skin prep 11 of the 14 opportunities. R3's eMAR dated December 1, 2021, through December 14, 2021, did not include the order for	01960		

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01960	Continued From page 54 brace when up, PRN when in bed. On December 14, 2021, at approximately 4:19 p.m. assistant director of nursing (ADON)-D stated R3's record should have documentation of RLE abrasion care, skin prep to 4th left toe, and brace when up, PRN when in bed. ADON-D confirmed this was lacking in R3's record. ADON-D further stated she faxed the physician to discontinue the cast care order "today." ADON-D stated when R3 moved in, the cast was already off and the order should have been discontinued at that time. The licensee's Medication and Treatment Orders revised June 22, 2020, indicated the RN is responsible for assuring that current, authorized prescriber orders for medications or treatments administered by the staff are kept on file in the resident's records, communicated to the resident providing education, and that changes in orders are addressed in the resident's service plan and are communicated to the other staff. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the	02040		

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02040	Continued From page 55 assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide the required documentation of the hazard vulnerability or safety risk assessment plan on and around the property. The hazards indicated on risk assessment must be reviewed and mitigated to protect all residents from harm. This has the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the clients). The findings include: On December 14, 2021, at approximately 12:30 p.m., staff requested the hazard vulnerability assessment plan (HVA) documentation from the Vice President of Operations (VPO)-A for review. The VPO-A stated the facility has not developed the HVA plan yet. Survey staff explained that an HVA plan was required to assess potential hazards on and around the property and mitigation to protect residents from harm from those identified hazards.	02040		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02040	Continued From page 56 On December 14, 2021, at approximately 12:30 p.m. and again at 4:30 p.m., VPO-A acknowledged the facility had not yet developed the required hazard vulnerability assessment and mitigation plan. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02040		
02140 SS=F	144G.83 Subd. 3 Supervising staff training Persons providing or overseeing staff training must have experience and knowledge in the care of individuals with dementia, including: (1) two years of work experience related to Alzheimer's disease or other dementias, or in health care, gerontology, or another related field; and(2) completion of training equivalent to the requirements in this section and successfully passing a skills competency or knowledge test required by the commissioner. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to designate a qualified person to oversee staff training in the care of individuals with dementia. 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), 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	02140		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33524	A. BUILDING: _____ B. WING _____	12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MOMENTS OF LAKEVILLE	16258 KENYON AVENUE LAKEVILLE, MN 55044

(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
02140	Continued From page 57 of the residents). The findings include: During the entrance conference on December 14, 2021, at approximately 1:19 p.m. executive director (ED)-B, stated she oversaw training staff in the care of individuals with dementia. On December 16, 2021, at approximately 12:00 p.m. ED-B stated she had completed an approved competency and knowledge test required for supervising staff in an assisted living facility with dementia care; however, ED-B was unable to provide a certificate or other documentation of completion to survey staff when requested. The licensee lacked a policy related to dementia training and the requirements of the trainer. No further information was provided. TIME PERIOD TO CORRECT: Fourteen (14) day	02140		
02240 SS=C	144G.90 Subdivision 1 Assisted living bill of rights; notification (a) An assisted living facility must provide the resident a written notice of the rights under section 144G.91 before the initiation of services to that resident. The facility shall make all reasonable efforts to provide notice of the rights to the resident in a language the resident can understand. (b) In addition to the text of the assisted living bill of rights in section 144G.91, the notice shall also contain the following statement describing how to file a complaint or report suspected abuse:	02240		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33524	A. BUILDING: _____ B. WING _____	12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MOMENTS OF LAKEVILLE	16258 KENYON AVENUE LAKEVILLE, MN 55044

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02240	Continued From page 58 "If you want to report suspected abuse, neglect, or financial exploitation, you may contact the Minnesota Adult Abuse Reporting Center (MAARC). If you have a complaint about the facility or person providing your services, you may contact the Office of Health Facility Complaints, Minnesota Department of Health. You may also contact the Office of Ombudsman for Long-Term Care or the Office of Ombudsman for Mental Health and Developmental Disabilities." (c) The statement must include contact information for the Minnesota Adult Abuse Reporting Center and the telephone number, website address, e-mail address, mailing address, and street address of the Office of Health Facility Complaints at the Minnesota Department of Health, the Office of Ombudsman for Long-Term Care, and the Office of Ombudsman for Mental Health and Developmental Disabilities. The statement must include the facility's name, address, e-mail, telephone number, and name or title of the person at the facility to whom problems or complaints may be directed. It must also include a statement that the facility will not retaliate because of a complaint. (d) A facility must obtain written acknowledgment from the resident of the resident's receipt of the assisted living bill of rights or shall document why an acknowledgment cannot be obtained. Acknowledgment of receipt shall be retained in the resident's record. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the current Minnesota Bill of Rights for Assisted Living Residents was provided to the resident and a written acknowledgement received for four of four	02240		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33524	A. BUILDING: _____ B. WING _____	12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MOMENTS OF LAKEVILLE	16258 KENYON AVENUE LAKEVILLE, MN 55044

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02240	Continued From page 59 residents (R3 R4, R1, and R2) with records reviewed. This had the potential to affect all residents. 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 potential to affect a large portion or all of the residents). The findings include: R3, R4, R1 and R2's records lacked evidence the residents received the Assisted Living Bill of Rights dated May 16, 2021. R3 R3 began receiving assisted living services on November 16, 2021. On December 14, 2021, at approximately 10:40 a.m. unlicensed personnel (ULP-E) was observed to put R3's call pendant necklace and socks on. R3's record lacked evidence R3 had received the Assisted Living Bill of Rights, dated May 16, 2021. R4 R4 began receiving services under the assisted living licensure on August 1, 2021. On December 14, 2021, at approximately 12:59 p.m. ULP-E was observed to empty R4's catheter leg bag. R4's record lacked evidence R4 had received the	02240		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33524	A. BUILDING: _____ B. WING _____	12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MOMENTS OF LAKEVILLE	16258 KENYON AVENUE LAKEVILLE, MN 55044

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02240	Continued From page 60 Assisted Living Bill of Rights dated May 16, 2021. R1 R1 began receiving services under the assisted living licensure on August 1, 2021. R1's Service Plan dated July 7, 2020, indicated R1 received services, which included bathing, grooming, dressing, treatments and medication administration. On December 14, 2021, at 12:10 p.m. licensed practical nurse (LPN)-I was observed to check R1's blood glucose and administer insulin. R1's record lacked evidence R1 had received the Assisted Living Bill of Rights dated May 16, 2021. R2 R2 began receiving assisted living services on November 29, 2021. R2's Service Plan dated November 28, 2021, indicated R2 received services, which included bathing, grooming, dressing, treatments and medication administration. On December 14, 2021, at 10:37 a.m. ULP-H was observed to provide redirection and ambulating with R2. R2's record lacked evidence R2 had received the Assisted Living Bill of Rights dated May 16, 2021. On December 14, 2021, at 5:06 p.m. vice president of operations (VPO)-A stated the facility had the new Assisted Living Bill of Rights dated May 16, 2021, but residents had not received it yet.	02240		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33524	A. BUILDING: _____ B. WING _____	12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MOMENTS OF LAKEVILLE	16258 KENYON AVENUE LAKEVILLE, MN 55044

(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
02240	Continued From page 61 On December 15, 2021, at approximately 3:55 p.m. director of nursing (DON)-C confirmed the current residents had not signed acknowledgement of receiving the current Assisted Living Bill of Rights as indicated above. The licensee lacked a policy on Assisted Living Bill of Rights. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02240		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors Subd. 8.Notice to visitors. (a) A facility must post a sign at each facility 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 the required notice was posted at the main entry way of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all current residents, staff and any visitors of the facility. This practice resulted in a level one violation (a violation that has not potential to cause more than	03090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33524	A. BUILDING: _____ B. WING _____	12/16/2021

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03090	Continued From page 62 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 potential to affect a large portion or all of the residents). The findings include: On December 13, 2021, at approximately 10:15 a.m. upon arriving at the establishment, an observation outside the front entrance, or just inside the front entrance, lacked the required posting for electronic monitoring devices. On December 13, 2021, at 3:19 p.m. vice president of operations (VPO)-A stated he believed the postings were in place in the original portion of the building that was under renovation at the time of the survey; however, they had not been moved or put into place since residents were moved into the newly added part of the building. VPO-A confirmed no posting was available related to the statutory language for electronic monitoring. 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
Saint Paul, Mn. 55164-0975
651-201-4500

Type: Full
Date: *12/13/21*
Time: 13:11:36
Report: 7958211253

Food and Beverage Establishment Inspection Report

Location:
The Moments Of Lakeville
16258 Kenyon Avenue
Lakeville, MN55044
Dakota County, 19

Establishment Info:
ID #: 0039397
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 9528731700
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.

3-500C Microbial Control: date marking

3-501.17B ** Priority 2 **

MN Rule 4626.0400B Mark the refrigerated, ready-to-eat, TCS food prepared and packaged in a processing plant and opened and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded. The date must not exceed the manufacturer's use-by-date.

UNSLICED ORTIONS OF OPEN "DELI-STYLE" HAM & TURKEY IN WALK-IN COOLER ARE NOT DATE MARKED. EXEC CHEF STATED THESE SEALED ITEMS WERE CUT OPEN ON 12/10 & WERE CORRECTLY DATE MARKED DURING INSPECTION.

Corrected on Site

4-300 Equipment Numbers and Capacities

4-302.13B ** Priority 2 **

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

ESTABLISHMENT DOES NOT HAVE A TEMP. MEASURING DEVICE, AS DESCRIBED IN ABOVE RULE, TO MEASURE UTENSIL SURFACE TEMPERATURE INSIDE HIGH TEMPERATURE DISH MACHINE. OBTAIN A DEVICE (THERMOMETER/LABEL/STIX) FOR DETERMINING MIN. UTENSIL SURFACE TEMP OF 160 DEGS.

Comply By: 12/27/21

6-300 Physical Facility Numbers and Capacities

6-301.14A

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

THERE AREN'T SIGNS AT THE 4 HANDWASH SINKS (2 IN FIRST FLOOR KITCHEN & 2 IN SECOND FLOOR KITCHEN) TO NOTIFY EMPLOYEES TO WASH HANDS. POST SIGNS AT ALL HAND SINKS AS REQ. BY ABOVE RULE.

Comply By: 12/27/21

Surface and Equipment Sanitizers

Wash temperature gauge: = at 153 Degrees Fahrenheit
Location: Hobart dish machine-first floor kitchen
Violation Issued: No

Final rinse temperature ga: = at 183 Degrees Fahrenheit
Location: Hobart dish machine-first floor kitchen
Violation Issued: No

Utensils surface temperatu: = at 167. Degrees Fahrenheit
Location: Hobart dish machine-first floor kitchen
Violation Issued: No

Ambient air temperature: = at 3 Degrees Fahrenheit
Location: Walk-in freezer
Violation Issued: No

Ambient air temperature: = at 37 Degrees Fahrenheit
Location: Walk-in cooler
Violation Issued: No

Ambient air temperature: = at 14 Degrees Fahrenheit
Location: Hoshizaki undercounter freezer
Violation Issued: No

Ambient air temperature: = at 4 Degrees Fahrenheit
Location: Hoshizaki undercounter cooler
Violation Issued: No

Ambient air temperature: = at 39 Degrees Fahrenheit
Location: Hoshizaki upright reach-in refrigerator
Violation Issued: No

Quaternary ammonium: = 200+ pp at Degrees Fahrenheit
Location: 3 compartment sink
Violation Issued: No

Quaternary ammonium: = 200+ pp at Degrees Fahrenheit
Location: Wiping cloth bucket
Violation Issued: No

Wash temperature gauge: = at 148 Degrees Fahrenheit
Location: Hobart dish machine-second floor kitchen
Violation Issued: No

Final rinse temperature ga: = at 182 Degrees Fahrenheit
Location: Hobart dish machine-second floor kitchen
Violation Issued: No

Utensils surface temperatu: = at 160.8 Degrees Fahrenheit
Location: Hobart dish machine-second floor kitchen
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Hold/Pasta
Temperature: 37 Degrees Fahrenheit - Location: Walk-in cooler
Violation Issued: No

Process/Item: Cold Hold/Egg noodles
Temperature: 36 Degrees Fahrenheit - Location: Walk-in cooler
Violation Issued: No

Process/Item: Cold Hold/Sliced turkey
Temperature: 36 Degrees Fahrenheit - Location: Walk-in cooler
Violation Issued: No

Process/Item: Cold Hold/Unsliced ham
Temperature: 37 Degrees Fahrenheit - Location: Walk-in cooler
Violation Issued: No

Process/Item: Cold Hold/Heavy cream
Temperature: 38 Degrees Fahrenheit - Location: Walk-in cooler
Violation Issued: No

Process/Item: Cold Hold/Shredded cheese
Temperature: 38 Degrees Fahrenheit - Location: Walk-in cooler
Violation Issued: No

Process/Item: Cold Hold/Cut melon
Temperature: 38 Degrees Fahrenheit - Location: Hoshizaki upright reach-in refrigerator
Violation Issued: No

Process/Item: Cold Hold/Milk
Temperature: 39 Degrees Fahrenheit - Location: Hoshizaki upright reach-in refrigerator
Violation Issued: No

Process/Item: Cold Hold/Creamer
Temperature: 40 Degrees Fahrenheit - Location: Hoshizaki undercounter cooler
Violation Issued: No

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

THIS INSPECTION WAS CONDUCTED BY GEORGE WAHL MDH SANITARIAN WITH EXEC. CHEF CHARLES PLAETZ. ALL ORDERS DOCUMENTED IN THIS REPORT WERE REVIEWED/DISCUSSED WITH MR. PLAETZ DURING AND AT THE END OF THE INSPECTION. ALL ORDERS WERE ALSO DISCUSSED WITH SUSAN KALIS, THE LEAD HRD EVALUATOR BEFORE I LEFT THE FACILITY.

THIS REPORT EMAILED TO SUSAN KALIS AND OTHER MEMBERS OF EVALUATION TEAM ON 12/14/21.

AT THE TIME OF THIS INSPECTION, ALL FOOD PREPARATION ACTIVITIES ARE DONE IN THE FIRST FLOOR KITCHEN. ALL FOODS ARE STORED IN THE FIRST FLOOR KITCHEN REFRIGERATION UNITS. WITHIN THE SECOND FLOOR KITCHEN, ONLY THE DISH MACHINE IS USED TO WASH, RINSE & SANITIZE PLATES, CUPS, GLASSES, UTENSILS, ETC. THAT ARE USED BY RESIDENTS DURING MEAL SERVICE. PREPARED MEALS ARE TRANSPORTED FROM THE FIRST FLOOR KITCHEN TO THE SECOND FLOOR KITCHEN VIA AN ELEVATOR THAT IS DIRECTLY ACCESSIBLE FROM BOTH KITCHENS.

REVIEWED THE SYMPTOMS OF FOODBORNE ILLNESSES AND THE REQUIREMENT TO MAINTAIN A DOCUMENTED RECORD OF ALL INSTANCES OF EMPLOYEES BEING ILL WITH EITHER VOMITING OR DIARRHEA AS REQUIRED BY THE MINNESOTA FOOD CODE & EXCLUDE ILL WORKERS FROM WORKING WITH FOOD & BEVERAGES UNTIL 24 HOURS AFTER SYMPTOMS HAVE ENDED.

MAINTAINING AN ACCURATE RECORD OF ALL INSTANCES OF EMPLOYEES BEING ILL WITH VOMITING AND/OR DIARRHEA MAY PROVIDE A FIRST INDICATION OF INCREASED RISK OF A FOODBORNE ILLNESS TO PERSONS AS A RESULT OF EATING AT A FOOD SERVICE ESTABLISHMENT.

**IF ANY RESIDENT OR STAFF MEMBER COMPLAINS OF ILLNESS, CONTACT THE MINNESOTA DEPARTMENT OF HEALTH AND PROVIDE THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER TO THE CUSTOMER. THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER IS 1-877-366-3455.

THE TEMPERATURE OF THE SANITIZING RINSE (UTENSIL SURFACE TEMPERATURE) INSIDE THE FIRST FLOOR KITCHEN DISH MACHINE WAS MEASURED AT 167.0 DEGREES F., WHICH IS ABOVE THE MINIMUM UTENSIL SURFACE TEMPERATURE OF 160 DEGREES F THAT IS REQUIRED BY THE MINNESOTA FOOD CODE. AT THIS TIME, THE DISH MACHINE IS PROPERLY SANITIZING.

THE TEMPERATURE OF THE SANITIZING RINSE (UTENSIL SURFACE TEMPERATURE) INSIDE THE SECOND FLOOR KITCHEN DISH MACHINE WAS MEASURED AT 160.8 DEGREES F., WHICH IS ABOVE THE MINIMUM UTENSIL SURFACE TEMPERATURE OF 160 DEGREES F THAT IS REQUIRED BY THE MINNESOTA FOOD CODE. AT THIS TIME, THE DISH MACHINE IS PROPERLY SANITIZING.

Food and Beverage Establishment Inspection Report

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 7958211253 of 12/13/21.

Certified Food Protection Manager: Charles Plaetz

Certification Number: FM58992 Expires: 08/16/23

Signed: _____
Charles Plaetz
Exec.Chef

Signed: _____
George Wahl, #7958
REHS
MDH - Freeman Building
651-201-4188
george.wahl@state.mn.us