



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

July 1, 2024

Licensee

Noah Assisting Living Inc
5100 Xerxes Avenue North
Minneapolis, MN 55430

RE: Project Number(s) SL35867015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 4, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

STATE CORRECTION ORDERS

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

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

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the

resident(s)/employee(s) identified in the correction order.

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **<https://forms.office.com/g/Bm5uQEPhVa>**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,



Jessie Chenze, Supervisor

State Evaluation Team

Email: Jessie.Chenze@state.mn.us

Telephone: 218-332-5175 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35867	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/04/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER NOAH ASSISTING LIVING INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5100 XERXES AVENUE NORTH MINNEAPOLIS, MN 55430
--	--

(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	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)</p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.</p> <p>Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance.</p> <p>INITIAL COMMENTS:</p> <p>SL35867015</p> <p>On June 3, 2024, through June 4, 2024, the Minnesota Department of Health conducted an initial survey at the above provider, and the following correction orders are issued. At the time of the survey, there were two residents receiving services under the provider's Assisted Living license.</p>	0 000	<p>Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction.</p> <p>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.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p> <p>THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.</p>	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35867	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/04/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER NOAH ASSISTING LIVING INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5100 XERXES AVENUE NORTH MINNEAPOLIS, MN 55430
--	--

(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
0 480	<p>Continued From page 1</p> <p>(13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated June 4, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.</p>	0 480		
0 650 SS=F	<p>144G.42 Subd. 8 Employee records</p> <p>(a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure,</p>	0 650		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35867	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/04/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER NOAH ASSISTING LIVING INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5100 XERXES AVENUE NORTH MINNEAPOLIS, MN 55430
--	--

(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
0 650	<p>Continued From page 2</p> <p>registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records contained required content for two of two employees (clinical nurse supervisor (CNS)-C, unlicensed personnel (ULP-E).</p> <p>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).</p> <p>The findings include:</p> <p>CNS-C CNS-C was hired on February 27, 2023, to</p>	0 650		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35867	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/04/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER NOAH ASSISTING LIVING INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5100 XERXES AVENUE NORTH MINNEAPOLIS, MN 55430
--	--

(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
0 650	<p>Continued From page 3</p> <p>provide direct care and services to the licensee's residents and oversight of the licensee's employees.</p> <p>On June 3, 2024, at 10:28 a.m., during the entrance conference, CNS-C identified herself as the CNS for the facility.</p> <p>CNS-C's employee record did not include documentation of all the required training to include: -annual review of provider's policies and procedures.</p> <p>ULP-E ULP-E was hired on January 19, 2022, to provide direct care services to residents of the facility.</p> <p>On June 4, 2024, at 7:13 a.m., the surveyor observed ULP-E remind R3 to brush R3's teeth.</p> <p>ULP-E's employee record did not include documentation of all the required training to include: -annual review of provider's policies and procedures.</p> <p>On June 3, 2024, at 2:20 p.m., house manager (HM)-B stated there was no evidence of a review of the provider's policies and procedures in any of the licensee's employee records for annual training. HM-B said employees reviewed the provider's policies and procedures yearly.</p> <p>Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0190, Subp. 6, effective October 2022, the licensee must maintain a record of staff training and competency required under this part and Minnesota Statutes, chapter 144G, that documents the following information for each</p>	0 650		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35867	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/04/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER NOAH ASSISTING LIVING INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5100 XERXES AVENUE NORTH MINNEAPOLIS, MN 55430
--	--

(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
0 650	<p>Continued From page 4</p> <p>competency evaluation, training, retraining, and orientation topic: (1) facility name, location, and license number; (2) name of the training topic or training program, and the training methodology, such as classroom style, web-based training, video, or one-to-one training; (3) date of the training and competency evaluation, and the total amount of time of the training and competency evaluation; (4) name and title of the instructor and the instructor's signature, and the name and title of the competency evaluator, if different from the instructor, and the evaluator's signature with a statement attesting that the employee successfully completed the training and competency evaluation; and (5) name and title of the staff person completing the training, and the staff person's signature with statement attesting that the staff person successfully completed the training as described in the training documentation.</p> <p>The licensee's Personnel Records policy dated August 1, 2021, noted a personnel record would be started for each staff member upon hire and at a minimum, all documents related to the following were kept in the personnel record, as applicable to job requirements, to include: -records of annual training and infection control training.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	0 650		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness	0 680		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35867	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/04/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER NOAH ASSISTING LIVING INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5100 XERXES AVENUE NORTH MINNEAPOLIS, MN 55430
--	--

(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
0 680	<p>Continued From page 5</p> <p>(a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have a written emergency preparedness plan (EPP) posted in a prominent area and developed with all the required content. This had the potential to affect all residents, staff and visitors.</p> <p>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</p>	0 680		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35867	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/04/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER NOAH ASSISTING LIVING INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5100 XERXES AVENUE NORTH MINNEAPOLIS, MN 55430
--	--

(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
0 680	<p>Continued From page 6</p> <p>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).</p> <p>The findings include:</p> <p>On June 3, 2024, at 11:04 a.m., during a tour of the facility with house manager (HM)-B, and clinical nurse supervisor (CNS)-C, the surveyor did not observe the facility's EPP in a prominent area.</p> <p>On June 3, 2024, at approximately 12:15 p.m., the surveyor requested the licensee's EPP plan for review. HM-B removed the facility's EPP binder from a drawer in the "sometimes" locked office.</p> <p>The licensee's EPP last reviewed January 17, 2024, failed to include the following:</p> <ul style="list-style-type: none"> - a missing resident plan that was reviewed quarterly - identification of the at-risk population needs like maintaining independence, communication, transportation, supervision, and medical care - procedures for tracking of staff and residents. <p>On June 3, 2024, at 12:28 p.m., the surveyor reviewed the licensee's EPP with HM-B and CNS-C. HM-B stated she was not aware the missing person policy required review quarterly. HM-B said for resident tracking and staff tracking, "we" (staff) would just talk about it, adding she (HM-B) would then be aware of locations. HM-B confirmed there was no procedure for the tracking of on duty staff and residents. HM-B and CNS-C stated residents are assessed for classification and ranked level 1,2, or 3 at the</p>	0 680		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35867	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/04/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER NOAH ASSISTING LIVING INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5100 XERXES AVENUE NORTH MINNEAPOLIS, MN 55430
--	--

(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
0 680	<p>Continued From page 7</p> <p>time of admission. HM-B and CNS-C confirmed the EPP did not include this information, it was located in the on-line system used. In addition, CNS-C stated, "I told you so" to HM-B regarding the required location of the EPP. CNS-C stated she was aware of the EPP location requirement from another facility she worked at. HM-B confirmed the EPP was not posted in a prominent area.</p> <p>Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0110, Subp. 4, effective October 2022, the assisted living director and clinical nurse supervisor must review the missing person plan at least quarterly and document any changes to the plan.</p> <p>Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0100, sections A and B, effective October 2022, assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.73, or successor requirements. This part references documents, specifications, methods, and standards in "State Operations Manual Appendix Z - Emergency Preparedness for All Providers and Certified Supplier Types: Interpretive Guidance," which is incorporated by reference.</p> <p>The licensee's Emergency Preparedness policy dated August 1, 2021, referenced CMS (Centers for Medicare and Medicaid Services) State Operations Manual Appendix Z; MN (Minnesota rules 4659.0100, noted: - the Emergency Disaster Plan was prominently posted on each floor of the facility -on initiation of assisted living, those residents with essential service needs are identified. The</p>	0 680		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35867	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/04/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER NOAH ASSISTING LIVING INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5100 XERXES AVENUE NORTH MINNEAPOLIS, MN 55430
--	--

(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
0 680	<p>Continued From page 8</p> <p>priority classification system included the following: level 1: high priority, level 2: moderate priority, level 3: low priority -the licensee staff members may not leave the residence when an emergency occurs; a staff member must remain there until a replacement arrived or the back-up plan is implemented.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-One (21) days</p>	0 680		
0 800 SS=F	<p>144G.45 Subd. 2 (a) (4) Fire protection and physical environment</p> <p>(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.</p> <p>This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors.</p> <p>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</p>	0 800		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35867	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/04/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER NOAH ASSISTING LIVING INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5100 XERXES AVENUE NORTH MINNEAPOLIS, MN 55430
--	--

(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
0 800	<p>Continued From page 9</p> <p>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).</p> <p>Findings include:</p> <p>On a facility tour on June 4, 2024, at 12:00 p.m., with the house manager (HM)-B, the surveyor noted an orange extension cord that went through the wall above the garage door. The surveyor explained to the HM-B, that all extension cords in a state-licensed facility must not be used for permanent use and shall follow manufacture recommendations.</p> <p>It was observed the main front door and the door from the office have double keyed deadbolt locks on them.</p> <p>The surveyor explained to the HM-B, that all marked egress doors shall be readily openable from the egress side without the use of a key or special knowledge or effort.</p> <p>It was observed the bathroom fan in the lower level was not working.</p> <p>It was observed the electrical connection in the electrical box above the water heater was improperly installed.</p> <p>During a facility tour on June 4, 2024, at 13:00 p.m., house manager HM-B, verified the deficient conditions at the time of discovery.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days.</p>	0 800		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35867	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/04/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER NOAH ASSISTING LIVING INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5100 XERXES AVENUE NORTH MINNEAPOLIS, MN 55430
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 810	Continued From page 10	0 810		
0 810 SS=F	<p>144G.45 Subd. 2 (b)-(f) Fire protection and physical environment</p> <p>(b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:</p> <ul style="list-style-type: none"> (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. <p>(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.</p> <p>(d) Fire safety and evacuation plans shall be readily available at all times within the facility.</p> <p>(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.</p> <p>(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.</p> <p>This MN Requirement is not met as evidenced by:</p>	0 810		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35867	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/04/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER NOAH ASSISTING LIVING INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5100 XERXES AVENUE NORTH MINNEAPOLIS, MN 55430
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 810	<p>Continued From page 11</p> <p>Based on observation, interview and record review, the licensee failed to provide required training and drills for residents. This had the potential to directly affect all residents, staff, and visitors.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).</p> <p>Findings include:</p> <p>On the facility tour on June 4, 2024, the surveyor noted at approximately 12:30 p.m. the evacuation maps were not up to date. Fire safety and evacuation plans shall up to date and be readily available at all times within the facility.</p> <p>A record review and interview were conducted on June 4, 2024, at approximately 1:15 p.m. with the house manager (HM)-B on the fire safety and evacuation plan, employee and resident training on the fire safety and evacuation plan, and evacuation drills for the facility.</p> <p>A record review of the available documentation indicated that the licensee failed to conduct required evacuation drills twice per year per shift with at least one drill conducted every other month. During interview the HM-B stated there were no available records documenting required evacuation drills and verified this deficient condition.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one</p>	0 810		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35867	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/04/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER NOAH ASSISTING LIVING INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5100 XERXES AVENUE NORTH MINNEAPOLIS, MN 55430
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 810	Continued From page 12 (21) days.	0 810		
0 970 SS=C	<p>144G.50 Subd. 5 Waivers of liability prohibited</p> <p>The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident. This had the potential to affect all residents.</p> <p>This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).</p> <p>The findings include:</p> <p>During the entrance conference on June 3, 2024, at 10:53 a.m., the surveyor asked for a copy of the licensee's assisted living contract. Housing manager (HM)-B stated all the contracted were the same. The assisted living contract was later</p>	0 970		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35867	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/04/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER NOAH ASSISTING LIVING INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5100 XERXES AVENUE NORTH MINNEAPOLIS, MN 55430
--	--

(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
0 970	<p>Continued From page 13</p> <p>provided reviewed by the surveyor.</p> <p>The (facility name) Assisted Living Contract included the clauses: -Miscellaneous Provisions: 1. the resident agrees that (name of facility) will not be liable to the resident for any personal injury or property damage (including, without limitation, damage to, or loss or theft of, automobiles or personal property of resident) suffered by the resident or the resident's agents, guests or invitees, unless and to the extent that the injury or damage is caused by the negligence of (name of facility) or its employees or agents. The resident hereby releases (name of facility) from liability for any personal injury or property damage suffered by the resident or the resident's agents, guests, or invitees, unless caused by the negligence of (name of facility) or its employees or agents. -Problem Resolution: 6. (name of facility) is not liable for any lost or stolen property but in the event that happens we will investigate and document it as an incident and report it to the relevant agencies.</p> <p>On June 4, 2024, at 10:07 a.m., R2's contract dated May 5, 2023, was reviewed with HM-B. HM-B stated no one had talked to her about the contract in the past, at other facilities. HM-B said the licensee got the contract from a consultant. HM-B said there were two clauses in the contract used that included a liability statement.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-One (21) days</p>	0 970		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35867	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/04/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER NOAH ASSISTING LIVING INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5100 XERXES AVENUE NORTH MINNEAPOLIS, MN 55430
--	--

(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
01060	Continued From page 14	01060		
01060 SS=F	<p>144G.52 Subd. 9 Emergency relocation</p> <p>(a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination.</p> <p>(b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum:</p> <ul style="list-style-type: none"> (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. <p>(c) The notice required under paragraph (b) must be delivered as soon as practicable to:</p> <ul style="list-style-type: none"> (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not 	01060		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35867	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/04/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER NOAH ASSISTING LIVING INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5100 XERXES AVENUE NORTH MINNEAPOLIS, MN 55430
--	--

(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
01060	<p>Continued From page 15</p> <p>returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section. currently known; and</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with required content to the resident, legal representative, and designated representative; and failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) when the resident did not return from the emergency relocation within four days for one of one resident (R2).</p> <p>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).</p> <p>The findings include:</p> <p>R2's diagnoses included schizophrenia (chronic brain disorder, combination of hallucinations, delusion), cannabis use disorder, diabetes, alcohol use disorder, cocaine use disorder, and amphetamine use disorder.</p> <p>R2's record included Resident Notes: -November 22, 2023: "The nurse had to take the client (resident) to the emergency room due to high blood sugar. Well, (sic) there, were at the</p>	01060		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35867	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/04/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER NOAH ASSISTING LIVING INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5100 XERXES AVENUE NORTH MINNEAPOLIS, MN 55430
--	--

(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
01060	<p>Continued From page 16</p> <p>emergency room the client claim that he was hearing voices in his head, and they were telling him to hurt himself. They waited in the psych ward (psychiatric/ hospital area specialized in serious mental illness) for a couple hours, and finally they admit him to the hospital. Hopefully tomorrow they'll move him to inpatient. but for now, he's staying at the hospital overnight." -December 1, 2023: " resident was readmitted to the house after he was hospitalized due to elevated blood sugar and is experiencing thoughts of hurting himself based on voices in his head...."</p> <p>R2's record lacked a written notice that contained, at a minimum: -the name and contact information for the location to which the resident had been relocated and any new service provider; -contact information for the OOLTC; - known and applicable, the approximate date or range of dates within which the resident was expected to return to the facility, or a statement that a return date is not currently known; -a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal.</p> <p>In addition, R2's record lacked notification to the OOLTC that the resident had been relocated and had not returned to the facility within four days.</p> <p>On June 4, 2024, at 9:52 a.m., housing manager (HM)-B stated she was not aware of the requirements and the need to notify OOLTC. HM-B stated she had not completed the written notice as required for any resident.</p>	01060		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35867	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/04/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER NOAH ASSISTING LIVING INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5100 XERXES AVENUE NORTH MINNEAPOLIS, MN 55430
--	--

(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
01060	<p>Continued From page 17</p> <p>The licensee's Discharge and Transfer of Residents policy dated August 1, 2021, noted in the event of an emergency relocation, the facility would, as soon as possible, provide written notice of Emergency Relocation to the following:</p> <ul style="list-style-type: none"> -the resident -the resident legal representative -the resident's designated representative -if the resident receives home and community-based services, the resident's case manager -if the resident had been relocated and not returned to (name of facility) within four days, the Office of Ombudsman for Long-Term Care. <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-One (21) days</p>	01060		
01500 SS=D	<p>144G.63 Subd. 5 Required annual training</p> <p>(a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include:</p> <ul style="list-style-type: none"> (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective 	01500		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35867	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/04/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER NOAH ASSISTING LIVING INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5100 XERXES AVENUE NORTH MINNEAPOLIS, MN 55430
--	--

(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
01500	<p>Continued From page 18</p> <p>gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases;</p> <p>(4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders;</p> <p>(5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and</p> <p>(6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person.</p> <p>(b) In addition to the topics in paragraph (a), annual training 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:</p> <p>(1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication;</p> <p>(2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or</p> <p>(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.</p>	01500		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35867	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/04/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER NOAH ASSISTING LIVING INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5100 XERXES AVENUE NORTH MINNEAPOLIS, MN 55430
--	--

(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
01500	<p>Continued From page 19</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employees received all required content of annual training for each 12 months of employment for one of three employees, (unlicensed personnel, (ULP)-E).</p> <p>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).</p> <p>The findings include:</p> <p>ULP-E was hired on January 19, 2022, to provide direct care services to residents of the facility.</p> <p>On June 4, 2024, at 7:13 a.m., the surveyor observed ULP-E remind R3 to brush R3's teeth.</p> <p>ULP-E's employee record included: -infection control techniques: completion date January 11, 2023. Completed for the January 2022, to 2023, time period.</p> <p>ULP-E's employee record lacked evidence ULP-E successfully completed annual training as required to include infection control for the time period of 2023 to 2024.</p> <p>On June 3, 2024, at 2:35 p.m., the surveyor, housing manager (HM)-B, and clinical nurse supervisor (CNS)-C reviewed ULP-E's training</p>	01500		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35867	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/04/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER NOAH ASSISTING LIVING INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5100 XERXES AVENUE NORTH MINNEAPOLIS, MN 55430
--	--

(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
01500	<p>Continued From page 20</p> <p>record. HM-B stated ULP-E had not completed annual training to include infection control. HM-B said that ULP-E missed that topic. HM-B checked her employee record for infection control review. HM-B's employee record included infection control. HM-B showed the surveyor a print out used the licensee to assign annual training for staff which included infection control.</p> <p>The licensee's Personnel Records policy dated August 1, 2021, noted a personnel record would be started for each staff member upon hire and at a minimum, all documents related to the following were kept in the personnel record, as applicable to job requirements, to include: -records of annual training and infection control training.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-One (21) days</p>	01500		
01620 SS=F	<p>144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring</p> <p>(c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment.</p> <p>(d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of</p>	01620		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35867	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/04/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER NOAH ASSISTING LIVING INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5100 XERXES AVENUE NORTH MINNEAPOLIS, MN 55430
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	<p>Continued From page 21</p> <p>services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident monitoring and reassessment to include all areas required on the uniform assessment tool per Minnesota Rule 4659.0150 for two of two residents (R2, R3) for change of condition related to smoking.</p> <p>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).</p> <p>The findings include:</p> <p>R2 R2's diagnoses include schizophrenia (chronic brain disorder, combination of hallucinations, delusion), cannabis use disorder, diabetes, alcohol use disorder, cocaine use disorder, and amphetamine use disorder.</p>	01620		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35867	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/04/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER NOAH ASSISTING LIVING INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5100 XERXES AVENUE NORTH MINNEAPOLIS, MN 55430
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	<p>Continued From page 22</p> <p>R2's service plan dated May 8, 2023, indicated R2 received bathing assistance, dressing assist, grooming assist, behavior management, medication administration, and housekeeping services.</p> <p>R2's safe smoking assessment dated May 6, 2023, noted: -client (resident) said he smokes one pack of cigarettes daily; he keeps his cigarettes in the bag. He smokes outside and puts the cigarette butt in the ash container -where do you store your smoking materials? "in my pocket" -is the resident able to smoke safely, independently, without intervention? yes,</p> <p>R2's record included resident notes, dated May 6, 2024: -client became upset he can no longer smoke in his room, so tried smoking on the patio, noticed the device he was smoking was not legal, took it away from him and threw it away -client then took out a second one and tried to smoke it in the alley way, asked him to return to the house, will provide further counseling -took away second device and asked client to stop smoking items that are not legal.</p> <p>On June 4, 2024, at 8:53 a.m., the surveyor observed R2 go outside and sit in a smoking area and smoke a cigarette.</p> <p>On June 4, 2024, at 11:44 a.m., the surveyor observed house manager (HM)-B ask unlicensed personnel (ULP)-D for the keys. HM-B opened the locked closet door (medication storage) and removed a package of cigarettes from a drawer and handed the package of cigarettes to R2.</p>	01620		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35867	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/04/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER NOAH ASSISTING LIVING INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5100 XERXES AVENUE NORTH MINNEAPOLIS, MN 55430
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	<p>Continued From page 23</p> <p>R3 R3's diagnoses include stroke (when part of the brain doesn't have enough blood flow, caused by a blocked artery or bleeding in the brain.)</p> <p>R3's service plan dated May 22, 2024, indicated R3 received bathing assistance, dressing assist, grooming assist, behavior management, medication administration, and housekeeping services.</p> <p>R3's safe smoking assessment dated May 27, 2021, noted: -client said he smokes one pack of cigarettes daily; he keeps his cigarettes in the bag. He smokes outside and puts the cigarette butts in the ash container -where do you keep your smoking materials: in the bag -is the resident able to smoke safety, independently, without intervention? yes, I (RN) watched client lite (sic) and put out cigarette, he is competent.</p> <p>On June 4, 2024, at 6:47 a.m., the surveyor observed ULP-E tell R3, "I'll bring them to you (cigarettes). ULP-E went downstairs to an area referred to as "the office" and got an unopened package of cigarettes for R3 out of a plastic bag. ULP-E stated R3 gets up early on "cigarette" day. ULP-E added, one package of cigarettes lasts R3 two days. R3 took the cigarettes outside with a lighter.</p> <p>On June 4, 2024, at 6:50 a.m., R3 returned into the facility after smoking. R3 took the opened package of cigarette and the lighter to R3's room.</p> <p>On June 4, 2024, at 7:13 a.m., R3 went outside to</p>	01620		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35867	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/04/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER NOAH ASSISTING LIVING INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5100 XERXES AVENUE NORTH MINNEAPOLIS, MN 55430
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	<p>Continued From page 24</p> <p>smoke. The surveyor observed ULP-E check on R3 outside smoking.</p> <p>On June 4, 2024, at 12:58 p.m., HM-B and clinical nurse supervisor (CNS)-C stated R3's smoking assessment had not been updated, as "nothing had changed." HM-B said "in the bag" meant in the bag the licensee kept R3's cigarettes in. HM-B and CNS-C confirmed R3's smoking pattern had changed since R3's admission.</p> <p>On June 4, 2024, at 1:11 p.m., HM-B stated she called the on-line system used to inquire if there were another area to assess for smoking? HM-B said she learned that smoking was not included in their 90-day assessment tool. HM-B stated R2 and R3's smoking assessments had not been updated since their admission. HM-B confirmed R2's smoking assessment should have been updated after R2 was found smoking in his room. HM-B added the smoking assessments did not include much detail and confirmed more information was needed on smoking assessments. HM-B and CNS-C confirmed R2 and R3's smoking assessments had not been updated as required.</p> <p>Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0140, Subp. 2, effective October 2022, a nursing assessment or reassessment under Minnesota Statutes, section 144G.70, subdivision 2, paragraphs (b) and (c), must be conducted on a prospective resident or resident receiving any of the assisted living services identified in Minnesota Statutes, section 144G.08, subdivision 9, clauses (6) to (12).</p> <p>B. The nursing assessment or reassessment under item A must:</p> <p>(1) address part 4659.0150, subpart 2, items A to</p>	01620		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35867	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/04/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER NOAH ASSISTING LIVING INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5100 XERXES AVENUE NORTH MINNEAPOLIS, MN 55430
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	<p>Continued From page 25</p> <p>N; (2) be conducted in person unless an exception under Minnesota Statutes, section 144G.70, subdivision 2, paragraph (b), applies; (3) be conducted using a uniform assessment tool that complies with part 4659.0150; and (4) be in writing, dated, and signed by the registered nurse who conducted the assessment.</p> <p>The licensee's Comprehensive Nursing Assessment policy dated August 1, 2021, noted The RN would conduct a comprehensive assessment utilizing a uniform assessment tool that addressed the following: -lifestyle preferences, including smoking, including safety factors.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-One (21) days</p>	01620		
01640 SS=F	<p>144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to</p> <p>(a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities.</p>	01640		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35867	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/04/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER NOAH ASSISTING LIVING INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5100 XERXES AVENUE NORTH MINNEAPOLIS, MN 55430
--	--

(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
01640	<p>Continued From page 26</p> <p>(c) The facility must implement and provide all services required by the current service plan.</p> <p>(d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable.</p> <p>(e) Staff providing services must be informed of the current written service plan.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure service plans were revised to include provided services for one of one resident (R2).</p> <p>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).</p> <p>The findings include:</p> <p>R2's diagnoses include schizophrenia (chronic brain disorder, combination of hallucinations, delusion), cannabis use disorder, diabetes, alcohol use disorder, cocaine use disorder, and amphetamine use disorder.</p> <p>R2's service plan dated May 8, 2023, indicated R2 received: -medication administration: two times per day -blood pressure: one day a week -oxygen saturation: one day a week -respirations: one day a week -pulse: one day a week</p>	01640		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35867	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/04/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER NOAH ASSISTING LIVING INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5100 XERXES AVENUE NORTH MINNEAPOLIS, MN 55430
--	--

(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
01640	<p>Continued From page 27</p> <p>-temperature: one day a week.</p> <p>On June 4, 2024, at 11:36 a.m., the surveyor observed unlicensed personnel (ULP)-D administer 1000 milligrams (mg) of metformin (diabetes) with correct technique to R2.</p> <p>R2's prescriber's orders dated May 1, 2024, included: -medication administration: three times per day -blood pressure, monthly -oxygen saturation: monthly -respirations: monthly -pulse: monthly -temperature: monthly These changes were not reflected on R2's service plan.</p> <p>On June 4, 2024, at 12:38 p.m., house manager (HM)-B reviewed R2's service plan with the surveyor. HM-B stated the service plan reviewed was from when services first started for R2. HM-B stated she would look for an updated service plan. HM-B printed out an updated service plan for R2 that was not signed.</p> <p>On June 4, 2024, at 12:46 p.m., HM-B stated she was not aware service plans needed to be updated each time a service changed. HM-B said that is what she was told/ understood from the consultant the licensee used. HM-B and clinical nurse supervisor (CNS)-C stated it "made sense" to review updated service plans with the licensee's residents. HM-B and CNS-C confirmed service plans were not revised as required.</p> <p>The licensee's Service Plan policy dated August 1, 2021, noted the service plan must be revised, if needed, based on resident review or reassessment. The initial service plan and any</p>	01640		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35867	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/04/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER NOAH ASSISTING LIVING INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5100 XERXES AVENUE NORTH MINNEAPOLIS, MN 55430
--	--

(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
01640	<p>Continued From page 28</p> <p>revisions are signed by a representative from the facility and the resident or resident's representative, indicating agreement with the services to be provided. The service plan and all revisions are entered into the resident's clinical record including notice of a change in a resident's fees when applicable.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-One (21) days</p>	01640		
01750 SS=D	<p>144G.71 Subd. 7 Delegation of medication administration</p> <p>When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has:</p> <ul style="list-style-type: none"> (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) prepared in writing specific instructions for each resident and documented those instructions for one of three residents (R2).</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or</p>	01750		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35867	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/04/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER NOAH ASSISTING LIVING INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5100 XERXES AVENUE NORTH MINNEAPOLIS, MN 55430
--	--

(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
01750	<p>Continued From page 29</p> <p>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).</p> <p>The findings include:</p> <p>R2's diagnoses include diabetes.</p> <p>R2's service plan dated May 8, 2023, indicated R2 received: -medication administration: two times per day.</p> <p>R2's Individualized Medication Management Plan dated June 4, 2024, included: -staff will administer insulin: Pick the injection site. Clean the area with alcohol or soap and water. If you use alcohol, allow the skin to dry to prevent stinging. Insert the needle straight into the skin. Count slowly to ten. Remove the needle from the skin. Check the site to see if insulin leaks out.</p> <p>On June 4, 2024, at 11:36 a.m., the surveyor observed unlicensed personnel (ULP)-D administer 1000 milligrams (mg) metformin (diabetes) with correct technique to R2.</p> <p>R2' Medication Administration Summary (record/MAR) dated May 1, 2024, through May 31, 2024, included: -Lantus Solostar (long-acting insulin) 100 units/milliliter (ml) inject 20 units subcutaneously (under the deepest skin layer) every 24 hours.</p> <p>R2's prescriber's orders dated May 1, 2024, included: -Lantus Solostar 100 units/milliliter (ml) inject 20</p>	01750		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35867	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/04/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER NOAH ASSISTING LIVING INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5100 XERXES AVENUE NORTH MINNEAPOLIS, MN 55430
--	--

(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
01750	<p>Continued From page 30</p> <p>units subcutaneously every 24 hours.</p> <p>On June 4, 2024, at 12:43 p.m., clinical nurse supervisor (CNS)-C stated she taught ULPs the injection sites for R2's Lantus. CNS-C confirmed R2's MAR did not include specific instructions for R2's Lantus to include to alternate injection sites and when to contact nursing if an issue arose.</p> <p>On June 4, 2024, at 1:36 p.m., the surveyor reviewed the medication information leaflet dated August 2022, with house manager (HM)-B for Lantus injections. HM-B confirmed R2's MAR did not include specific instructions for R2's Lantus.</p> <p>The instructions for Lantus dated August 2022, noted it is important to rotate injection sites to avoid lipohypertrophy (pitted or thickened skin), or localized cutaneous amyloidosis (skin with lumps) at the injection sites. Do not use the same spot for each injection or inject where the skin is pitted, thickened lumpy, tender, bruised, scaly, hard, scarred, or damaged.</p> <p>The licensee's Medication Administration policy dated August 1, 2021, noted the registered nurse may delegate medication administration to an unlicensed staff member according to the following protocol: -the registered nurse had prepared written instructions for the home health aide (ULP) in the proper methods to administer medications with respect to each resident.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>	01750		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35867	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/04/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER NOAH ASSISTING LIVING INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5100 XERXES AVENUE NORTH MINNEAPOLIS, MN 55430
--	--

(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
01760	Continued From page 31	01760		
01760 SS=D	<p>144G.71 Subd. 8 Documentation of administration of medication</p> <p>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.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure medications were administered as ordered for one of three residents (R1).</p> <p>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).</p> <p>The findings include:</p> <p>R1's diagnoses included diabetes, anxiety disorder, hyperlipidemia (high cholesterol) and</p>	01760		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35867	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/04/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER NOAH ASSISTING LIVING INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5100 XERXES AVENUE NORTH MINNEAPOLIS, MN 55430
--	--

(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
01760	<p>Continued From page 32</p> <p>schizoaffective disorder mental health disorder that is marked by a combination of schizophrenia symptoms, such as hallucinations or delusions and mood disorder, such as depression or mania).</p> <p>R1's service plan dated September 6, 2023, indicated R1 received medication administration daily.</p> <p>R1's medication administration record (MAR) dated March 1, 2024, through March 14, 2024, indicated R1 received the following medication: -metformin (diabetes) ER (extended release) 500 milligrams (mg), take two tablets in the morning with a meal daily -metformin ER 500 mg, take two tablets in the evening with a meal daily.</p> <p>R1's prescriber's order dated November 16, 2023, included: -metformin HCl ER 500 mg tablets: take four tablets (2000 mg) by mouth daily.</p> <p>On June 3, 2024, at 12:12 p.m., the surveyor reviewed R1's MAR and prescriber's orders with clinical nurse supervisor (CNS)-C. CNS-C stated R1 wanted to take the ordered metformin twice daily, adding that was what R1 was used to doing. CNS-C stated she had called the pharmacy that pre-packed the medication to get the medication set up that way. CNS-C stated the pharmacy may have an order to set up metformin ER twice daily. CNS-C confirmed R1's metformin ER was not administered as prescribed.</p> <p>The licensee's Medication Orders policy dated August 1, 201, noted (name of facility) would administer medications as prescribed by the authorized prescriber and in accordance with all</p>	01760		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35867	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/04/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER NOAH ASSISTING LIVING INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5100 XERXES AVENUE NORTH MINNEAPOLIS, MN 55430
--	--

(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
01760	Continued From page 33 rights defined in the Home Care Bill of Rights and in the Health Insurance Portability and Accountability Act. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of one medication refrigerator maintained an acceptable temperature to ensure the medications were stored according to manufacturer's recommendations. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On June 3, 2024, at approximately 11:00 a.m., the surveyor toured the facility with clinical nurse	01880		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35867	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/04/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER NOAH ASSISTING LIVING INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5100 XERXES AVENUE NORTH MINNEAPOLIS, MN 55430
--	--

(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
01880	<p>Continued From page 34</p> <p>supervisor (CNS)-C and house manager (HM)-B including a review of the locked medication refrigerator in the office. HM-B stated she was not sure what the temperature of the refrigerator should be. CNS-C stated the temperature of the refrigerator should be 37 degrees. The surveyor inquired what the current temperature of the locked refrigerator was? HM-B and CNS-C were not able to locate a thermometer in the locked medication refrigerator. HM-B stated they (licensee) were not aware that the medication refrigerator's temperature was to be monitored. HM-B said they do monitor the food refrigerator, adding it made sense to also monitor the medication refrigerator. HM-B confirmed the medication refrigerator's temperature was not monitored as required.</p> <p>The medication refrigerator contained: -one unopened Lantus (long acting) 100 units/ml insulin pen for R2.</p> <p>The manufacturer's instructions for Lantus insulin pens dated August 2022, indicated unopened insulin pens should be stored in the refrigerator (36 to 46 degrees Fahrenheit). Do not allow the Lantus to freeze.</p> <p>The licensee's Control of Medications policy dated August 1, 2021, noted when the licensee was providing storage of medications outside of the resident's private living space, all prescription drugs were securely locked in substantially constructed compartments according to the manufacturer's directions.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>	01880		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35867	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/04/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER NOAH ASSISTING LIVING INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5100 XERXES AVENUE NORTH MINNEAPOLIS, MN 55430
--	--

(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
01910 SS=D	<p>144G.71 Subd. 22 Disposition of medications</p> <p>(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.</p> <p>(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.</p> <p>(c) Upon disposition, the facility must 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.</p> <p>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 medications as required for one of two residents (R1) upon discharge.</p> <p>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</p>	01910		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35867	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/04/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER NOAH ASSISTING LIVING INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5100 XERXES AVENUE NORTH MINNEAPOLIS, MN 55430
--	--

(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
01910	<p>Continued From page 36</p> <p>situation has occurred only occasionally).</p> <p>The findings include:</p> <p>During the entrance conference on June 3, 2024, at 10:30 a.m., clinical nurse supervisor (CNS)-C and house manager (HM)-B stated the licensee provided medication management services to the residents at the facility.</p> <p>R1's diagnoses included diabetes, anxiety disorder, hyperlipidemia (high cholesterol) and schizoaffective disorder mental health disorder that is marked by a combination of schizophrenia symptoms, such as hallucinations or delusions and mood disorder, such as depression or mania).</p> <p>R1's service plan dated September 6, 2023, indicated R1 received medication administration daily.</p> <p>R1's Medication Administration Summary dated March 1, 2024, through March 14, 2024, indicated R1 received the following medications: -escitalopram (antidepressant/anxiety) ten milligrams (mg) and five mg, daily -gabapentin (nerve pain) 100 mg, every morning -metformin (diabetes) 500 mg, take two tablets in the morning with a meal daily -propranolol (high blood pressure) 10 mg twice, daily -ziprasidone (hallucinations) 40 mg twice, daily -atorvastatin (high cholesterol) 20 mg, at night -gabapentin 300 mg daily (nerve pain), at bedtime -metformin 500 mg (diabetes), take two tablets in the evening with a meal daily.</p> <p>R1's provider orders dated October 11, 2023, October 18, 2023, November 15, 2023,</p>	01910		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35867	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/04/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER NOAH ASSISTING LIVING INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5100 XERXES AVENUE NORTH MINNEAPOLIS, MN 55430
--	--

(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
--------------------	--	---------------	---	--------------------

01910	<p>Continued From page 37</p> <p>November 16, 2023, and December 20, 2023, included the above medications.</p> <p>R1's record included: -Discharge/Transfer Summary dated March 27, 2024: discharged to: Ramsey County Correctional Facility, incarcerated -31-page report dated March 27, 2024, which included: -medication name, strength, prescription number, and scheduled time (AM/ morning, PM/evening, 11:00 p.m.,) -"we are sending the following medications with you to be administered by you or a responsible party while you are absent from the facility. By accepting this document, you or your responsible party acknowledges that you have been instructed on the correct use and administration of these medication by the staff member releasing them. You are then assuming responsibility for the correct use and administration of these medications. Any questions or concerns should be addressed to the facility identified here" - Report authenticated by unlicensed personnel (ULP)-E with a statement that noted, "have released the above listed medications in the quantity specified to (name).</p> <p>R1's record did not include the quantity of the medication sent.</p> <p>On June 3, 2024, at 11:59 a.m., the surveyor reviewed R1's discharge summary and medication disposition with HM-B. HM-B stated the licensee thought R1 was discharged for a "short time."</p> <p>On June 3, 2024, at 12:01 p.m., HM-B said she was aware of the required discharge information.</p>	01910		
-------	--	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35867	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/04/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER NOAH ASSISTING LIVING INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5100 XERXES AVENUE NORTH MINNEAPOLIS, MN 55430
--	--

(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
01910	<p>Continued From page 38</p> <p>HM-B and CNS-C said R1's record did not include the required information to include the quantity of medication. HM-B added the required information was not in R1's record and "was not done for this situation (resident incarcerated)."</p> <p>The licensee's Disposition and Disposal of Medications policy dated August 1, 2021, noted upon disposition, the licensee would document the following information in the client record: -name, strength and prescription number of medication, as applicable -quantity -method of disposition or to whom the medications were given -date of disposition -name (s)/signature(s) of staff or other individuals involved in disposition -if applicable, to whom the medications were given.</p> <p>The licensee's Discharge and Transfer of Resident's policy dated August 1, 2021, noted the discharge summary shall include: -a reconciliation of all pre-discharge medications with the resident's post discharge prescribed and over the counter medications.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>	01910		
02430 SS=F	<p>144G.91 Subd. 15 Confidentiality of records</p> <p>(a) Residents have the right to have personal, financial, health, and medical information kept private, to approve or refuse release of information to any outside party, and to be</p>	02430		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35867	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/04/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER NOAH ASSISTING LIVING INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5100 XERXES AVENUE NORTH MINNEAPOLIS, MN 55430
--	--

(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
02430	<p>Continued From page 39</p> <p>advised of the assisted living facility's policies and procedures regarding disclosure of the information. Residents must be notified when personal records are requested by any outside party. (b) Residents have the right to access their own records.</p> <p>This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure resident's personal health and medical information was kept private for two of two residents (R2, R3) observed during medication administration</p> <p>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).</p> <p>The findings include:</p> <p>R2 R2's diagnoses include schizophrenia (chronic brain disorder, combination of hallucinations, delusion), cannabis use disorder, diabetes, alcohol use disorder, cocaine use disorder, amphetamine use disorder.</p> <p>R2's service plan dated May 08, 2023, indicated R2 received medication administration.</p> <p>On June 4, 2024, at 11:36 a.m., the surveyor observed unlicensed personnel (ULP)-D log into the computer positioned on a table in the</p>	02430		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35867	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/04/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER NOAH ASSISTING LIVING INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5100 XERXES AVENUE NORTH MINNEAPOLIS, MN 55430
--	--

(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
02430	<p>Continued From page 40</p> <p>common's area/living area, near the front entrance to the facility. ULP-D reviewed R2's electronic medication administration record (EMAR). ULP-D left R2's EMAR visible on the computer screen and walked to a locked closet door located in a hallway on the other side of the common's area that was located near the bathroom and three bedrooms. ULP-D unlocked the closet door and removed a bubble pack of medication from a drawer for R2. ULP-D returned to the computer screen to double check the bubble pack with the EMAR. ULP-D left R2's EMAR visible when she took the bubble pack of medication to R2's room. After ULP-D administered R2's medication she returned to the computer and documented R2's medication as given. The surveyor did not observe ULP-D close or minimize the computer screen with R2's EMAR visible.</p> <p>R3 R3's diagnoses include stroke (when part of the brain doesn't have enough blood flow, caused by a blocked artery or bleeding in the brain.)</p> <p>R3's service plan dated May 22, 2024, indicated R3 received medication administration.</p> <p>On June 4, 2024, at 11:39 a.m., the surveyor observed ULP-D review R3's EMAR. The surveyor did not observe ULP-D close or minimize the computer screen with R3's EMAR visible.</p> <p>On June 4, 2024, at 11:40 a.m., ULP-D removed the gloves she had on, and when to the bathroom sink and washed her hands. R3's EMAR was visible on the computer screen.</p> <p>On June 4, 2024, at 11:41 a.m., ULP-D went to</p>	02430		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35867	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/04/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER NOAH ASSISTING LIVING INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5100 XERXES AVENUE NORTH MINNEAPOLIS, MN 55430
--	--

(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
02430	<p>Continued From page 41</p> <p>the kitchen and got a new pair of gloves. ULP-D went to R3's room to inform him that she would be administering R3's medications. ULP-D went to the computer to review R3's EMAR. ULP-D went to the locked medication closet and removed a bubble pack of medication and an eye drop vial from a drawer for R3. ULP-D took the bubble pack of medication and the eye drop vial to the computer to double check the medication with R3's EMAR. ULP-D left R3's EMAR visible when she took the medication to R2's room. The surveyor did not observe ULP-D close or minimize the computer screen with R3's EMAR visible.</p> <p>On June 4, 2024, at 11:46 a.m., ULP-D returned to the computer and documented R3's medication as administered.</p> <p>On June 4, 2024, at 11:47 a.m., ULP-D stated the computer screen was supposed to be closed. ULP-D added the residents were in their rooms and she was there by herself. ULP-D acknowledged the front door was not locked and if anyone entered the facility R2 and R3's EMARs had been visible and not protected.</p> <p>On June 4, 2024, at 11:50 a.m., house manager (HM)-B and clinical nurse supervisor (CNS)-C stated the computer screen should not have been left visible, adding education would be done with ULP. HM-B said some ULP's use the "phone" (handheld with access to records) to document medication administration, not leaving information visible.</p> <p>The licensee's Confidentiality policy dated August 1, 2021, noted all resident information, including but not limited to personal, financial, and medical data, was kept confidential and released only in</p>	02430		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35867	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/04/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER NOAH ASSISTING LIVING INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5100 XERXES AVENUE NORTH MINNEAPOLIS, MN 55430
--	--

(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
02430	<p>Continued From page 42</p> <p>the following situations: -to authorized persons with an appropriate Release of Information -according to law -to employees or contractors of the licensee -to another home care provider, a health care practitioner or provider, or an inpatient facility that required information to provide services to the resident, but only the information that was necessary to provide services -to representatives of the commissioner authorized to survey or investigate home care providers.</p> <p>The Minnesota Bill of Rights for Assisted Living Residents dated November 8, 2022, noted residents have the right to have personal, financial, health, and medical information kept private.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>	02430		



Minnesota Department of Health
Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: 06/04/24
Time: 10:00:00
Report: 1039241155

Food and Beverage Establishment Inspection Report

Page 1

Location:

Noah Assisting Living Inc
5100 Xerxes Avenue North
Minneapolis, MN55430
Hennepin County, 27

Establishment Info:

ID #: 0037665
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9526490662
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.

3-300B Protection from Contamination: cross-contamination, eggs

3-302.11A(1) **** Priority 1 ****

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

SHELL EGGS STORED OVER PRODUCE, READY TO EAT FOODS IN REFRIGERATOR. DISCUSSED HOW TO SEPARATE RAW ANIMAL PRODUCE FROM OTHER FOODS WITH PERSON-IN-CHARGE. COMPLY WITH ABOVE. GUIDANCE DOCUMENT SENT WITH REPORT.

Comply By: 06/04/24

3-500D Microbial Control: disposition of food

3-501.18A **** Priority 1 ****

MN Rule 4626.0405A Discard all TCS food prepared in the establishment or opened commercially packaged food when the time exceeds 7 days from the preparation or opening date or if the container or package is not marked.

CONTAINER OF DAIRY MILK HELD IN REFRIGERATOR FOR 9 DAYS. PERSON-IN-CHARGE WILL DISCARD MILK.

Comply By: 06/04/24

Food and Equipment Temperatures

Process/Item: MILK

Temperature: 39 Degrees Fahrenheit - Location: COLD HOLD IN REFRIGERATOR

Violation Issued: No

Type: Full
Date: 06/04/24
Time: 10:00:00
Report: 1039241155
Noah Assisting Living Inc

Food and Beverage Establishment Inspection Report

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

The inspection was completed with the person in charge and reviewed with MDH nurse evaluator Cyndi Casey.

The kitchen is of residential build and should serve food for same-day service only. Sealed packages of non-TCS foods are stored in basement cupboard.

The kitchen has wood cabinets with hollow base, tile floor, painted walls and ceiling and laminate countertops.

The kitchen finishes and surfaces are clean and well maintained.

The kitchen refrigerator/freezer are of residential grade.

A 2-compartment sink is present in kitchen. 1 compartment is designated for handwashing only.

An NSF residential dishwashing machine is present in the kitchen. Per color-change thermo test strip, the dish washing machine achieves a utensil surface temperature of 150 degrees F for extended time to sanitize.

A supply of single-use gloves is present in kitchen. A thin-probe food thermometer is present in kitchen. A supply of color-change thermo test strips are present for testing the dishwashing machine utensil surface temperature.

Discussed the following with the person-in-charge: minimum cook temps for animal proteins, food source, foodborne illness symptoms and exclusion of ill employees, avoiding bare hand contact with ready to eat foods, handwashing, sanitizing, thawing of frozen meat.

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 1039241155 of 06/04/24.

Certified Food Protection Manager: Yaasin Iaamac

Certification Number: FM117902 Expires: 06/11/26

Inspection report reviewed with person in charge and emailed.

Signed: _____

Faisa Jama
house manager

Signed:  _____

Aron Goodner
Public Health Sanitarian I
Freeman Building
aron.goodner@state.mn.us