Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF REMOVAL OF CONDITIONS ON PROVISIONAL LICENSE - LICENSE GRANTED

Electronic Delivery

March 28, 2025

Licensee
Abundant Home Health Services LLC
9524 Morgan Avenue North
Brooklyn Center, MN 55444

RE: Initial License Number 412913
Health Facility Identification Number (HFID) 40134
Project Number(s) SL40134015

Dear Licensee:

On February 24, 2025, The Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed October 24, 2024. The follow-up survey found the facility to be in substantial compliance. Based on these findings, the condition(s) on the license were removed effective March 28, 2025.

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

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.

Furthermore, the follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the 10242024 initial survey.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a), state correction orders issued pursuant to the last survey completed on October 24, 2024, found not corrected at the time of the follow-up follow-up survey and/or subject to a penalty assessment are as follows:

1890-Prescription Drugs-144g.71 Subd. 20

The details of the violations noted at the time of this follow-up survey completed on February 24, 2025 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

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

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

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's 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

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

Sincerely,

Rick Michals, J.D.
Executive Regional Operations Manager

Minnesota Department of Health
Health Regulation Division

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40134	A. BUILDING: _____ B. WING _____	R 02/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABUNDANT HOME HEALTH SERVICES LLC	9524 MORGAN AVENUE NORTH BROOKLYN CENTER, MN 55444

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SL40134015-1 On February 24, 2025, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on October 24, 2024. At the time of the survey, there were three (3) residents receiving services under the Assisted Living License. As a result of the follow-up survey, the following orders were reissued.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
{0 480} SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	{0 480}		

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

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{0 480}	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by:	{0 480}	Not reviewed during this survey.	
{01890} SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure time-sensitive medications were labeled with the date opened for one of two residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	{01890}		

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{01890}	Continued From page 3 was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3 was admitted to licensee on March 31, 2024. R3's Service Agreement/Service Plan dated March 31, 2024, indicated R3 required medication administration and medication reminders. R3's Assessment dated February 21, 2025, indicated R3 required, "full medication management and set up" and all medications would be stored by the licensee. On February 24, 2024, at 10:35 a.m., the surveyor completed an audit of the licensee's medication storage cart. R3's Basaglar KwikPen (an adjustable dose insulin administration device commonly referred to as an insulin pen) was noted to be in R3's assigned plastic bin and lacked a labeled date for when the insulin pen was initially opened or first used. On February 24, 2025, at 11:30 a.m., clinical nurse supervisor (CNS)-A stated the licensee had been issued a citation for the same failure to label an opened-on date for time-sensitive medications previously and had worked on educating staff on the licensee's policy and procedure. CNS-A stated the insulin pen was first used that morning, but the staff who opened it, had forgotten to label it. CNS-A obtained R3's previous insulin pen with an included opened-on date label on the pen cap, and stated R3's current undated insulin pen should have been labeled in a similar manner.	{01890}		

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{01890}	Continued From page 4 The Basaglar KwikPen Instructions for Use revised November 2023, read under section 16.2 Storage and Handling, "In-use BASAGLAR prefilled pens must be used within 28 days or be discarded, even if they still contain BASAGLAR." The licensee's undated Remediation Plan: Medication Management and Administration was identified by CNS-A as licensee's Plan of Correction (POC) lacked identification of a POC for management of undated time-sensitive medications. The licensee's undated Medication Policy: Prescription Drugs & Prohibition indicated, "each prescription container must bear the original label with legible information, including the expiration date or beyond-use date for time sensitive medications." No further information was provided.	{01890}		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF PROVISIONAL EXTENSION AND CONDITIONAL LICENSE

Electronically Delivered

December 11, 2024

Licensee
Abundant Home Health Services LLC
9524 Morgan Avenue North
Brooklyn Center, MN 55444

RE: Provisional Conditional License Number 412913
Health Facility Identification Number (HFID) 40134
Project Number(s) SL40134015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on October 24, 2024, for the purpose of assessing compliance with state licensing statutes. Based on the survey results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, pursuant to Minn. Stat. § 144G.16, Subd. 3(b)(2), MDH is extending the provisional license for 90-days and applying conditions necessary to bring the facility into substantial compliance. The provisional license extension and conditions are due to expire **March 11, 2025**.

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

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

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

authorized in § 144G.20.

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

MDH may assess fines based on the level and scope of the orders outlined below. The total amount of **potential** fines that may be assessed related to these correction orders is $3,000.00. **MDH is not imposing these fines against your provisional license at this time.**

St - 0 - 0470 - 144g.41 Subdivision 1 - Minimum Requirements $3,000.00

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the provisional licensee must document actions taken to comply with the correction orders and immediately correct any reissued orders outlined on the state form; however, plans of correction are not required to be submitted for approval. **If corrections are not made, MDH may impose fines as described above and in accordance with Minnesota Statutes 144G.**

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

CONDITIONAL LICENSE ISSUED:

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

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

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

b. **No new admissions:** Abundant Home Health Services LLC will not admit any new residents under its conditional provisional assisted living facility license until MDH removes the "no new admissions" condition. Abundant Home Health Services LLC must provide the Department:

   i. A list of the names and birthdates of any individuals Abundant Home Health Services LLC is currently in the process of admitting. These individuals will be able to continue the admittance process.

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

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

requirements.

d. Reports: The RN consultant will provide MDH with regular reports at intervals specified by MDH. Reports will begin on a weekly basis until MDH notifies Abundant Home Health Services LLC and the RN consultant about a change. Each report will be electronically submitted to Brandon Mueller, State Evaluation Team, Health Regulation Division, at Brandon.W.Mueller@state.mn.us. Brandon Mueller can be reached at 651-247-2064 (office) with questions about reports. The content of the reports will include information such as:

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

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

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

g. Corrective Action Plan: Abundant Home Health Services LLC will develop and work within a corrective action plan (CAP). The CAP is a working document that includes at least the following information:

i. A statement of the concern

ii. A description of what will happen to correct the concern
iii. A target date for when each correction will be complete
iv. Who is responsible to make sure it happens
v. Current status of correction work
vi. Description of a plan to monitor and ensure ongoing substantial compliance for each corrected order

RESULTS OF FOLLOW-UP EVALUATION DURING THE CONDITIONAL PROVISIONAL LICENSE PERIOD:
MDH will determine if Abundant Home Health Services LLC is in substantial compliance based on the results of the follow up survey. MDH will make this determination within the 90-day conditional provisional license period. If MDH determines Abundant Home Health Services LLC is in substantial compliance on the follow up survey, MDH will remove the conditions and grant the assisted living facility license to Abundant Home Health Services LLC. If MDH determines Abundant Home Health Services LLC is not in substantial compliance, MDH may deny the license pursuant to Minn. Stat. § 144G.16, Subd. 3 (b) (2).

REQUEST FOR RECONSIDERATION:
Pursuant to Minn. Stat. §144G.16, Subd. 4, if a provisional licensee whose assisted living facility license has been denied, or extended with conditions, disagrees with the action taken against the provisional license under this section, the provisional licensee may request a reconsideration no later than 15 calendar days after provisional licensee receives notice of the action. **This is your only ability to request a reconsideration under this enforcement action.**

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

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 Brandon Mueller directly at: 651-247-2064.

Sincerely,

Rick Michals, J.D.
Executive Regional Operations Manager

Minnesota Department of Health
Health Regulation Division

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 000	Initial Comments ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL40134015-0 On October 21, 2024, through October 24, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were three resident(s); three receiving services under the Provisional Assisted Living Facility license. An immediate correction order was identified on October 23, 2024, issued for SL40134015-0, tag identification 0470. During the survey, the licensee took action to mitigate the immediate risk. However, noncompliance remained, and the scope and level remain unchanged.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 470 SS=I	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470		

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0 470	Continued From page 1 determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a staffing plan to meet the scheduled and reasonably foreseeable unscheduled needs of the residents. This had the potential to affect all residents. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death,	0 470	During the survey, the licensee took action to mitigate the immediate risk. However, noncompliance remained, and the scope and level remain unchanged.	

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0 470	Continued From page 2 or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On October 23, 2024, from 6:30 a.m., to 7:00 a.m., during continuous observation, there was only one staff member on-site within the facility. The licensee's staff schedule dated October 21, 2024, to November 3, 2024, indicated that there was supposed to be two staff members on for the night shift from 7:00 p.m., to 7:00 a.m., and then two staff members on-site from 7:00 a.m., to 7:00 p.m. During the survey, on October 23, 2024, the licensee's census was three residents. R1 was admitted to the licensee on July 16, 2024. R1's Service Plan - Modification dated October 15, 2024, indicated R1 received assistance with activities, appointment assistance, bathing, bedmaking, compression stockings, dressing, equipment care- respiratory, escort/mobility assistance, grooming, housekeeping, incontinence care, laundry, behavior management, meal assistance, medication administration, medication setup, nail care, position/reposition, vitals, shopping assistance, socialization, and therapeutic exercises. R1's diagnosis included morbid obesity, hypercapnic, cognitive impairment, osteoarthritis, pre-diabetic, failure to thrive, hypertension, Afib,	0 470		

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0 470	Continued From page 3 cirrhosis, debility, cyanosis, oxygen dependence, lymphedema-bilateral legs, diabetic neuropathies-bilateral legs, dyslipidemia, acquired burn penis, adjustment disorder with depressed mood, congestive heart failure, right ventricular failure, persistent tachycardia, sleep apnea, acute hypoxemic respiratory failure, hypoxemia, and obstructive sleep apnea. R1's most current 90-day assessment dated October 15, 2024, indicated R1 required two-person transfer. The emergency response section of the assessment indicated the following: "Resident is unable to move independently. Resident requires full assist with transfer and evacuation. Staff will also seek assistant from local fire dept due to mobility. Resident is obese." On October 23, 2024, at 8:38 a.m., clinical nurse supervisor (CNS)-A stated there was normally two scheduled people for all shifts, but this morning they needed to escort another resident to an appointment and there was no available staff to cover. On October 23, 2024, at 10:53 a.m., CNS-A stated there was no plan in place for completing an emergency one-person transfer with R1, and the licensee lacked supplies needed to safely complete a one-person transfer. CNS-A stated that staff were trained to complete all transfers for R1 using a Hoyer lift (mechanical lift used to transfer a person that is unable to always bear weight) with two staff members. The licensee's undated Admission Policy indicated staff shall be sufficient in qualifications and numbers to adequately provide the services agreed to in the Service Plan.	0 470		

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0 470	Continued From page 4 Assisted Living Facilities: Minnesota Rules Chapter 4659.0180 Subpart 5., indicates, "A minimum of two direct-care staff must be scheduled and available to assist at all times whenever a resident requires the assistance of two direct-care staff for scheduled reasonably foreseeable and unscheduled needs, as reflected in the resident's assessments and service plan." No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This 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:	0 480		

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0 480	Continued From page 5 Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated October 22, 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.	0 480		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (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.	0 680		

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0 680	Continued From page 6 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On October 21, 2024, at 11:27 a.m., clinical nurse supervisor (CNS)-A retrieved the licensee's emergency preparedness plan (EPP) from the basement storage closet. CNS-A stated the licensee's EPP was typically stored in the locked basement closet which contained overflow documentation for staff and residents. The licensee's written emergency disaster preparedness plan lacked evidence of the following required content: - Policies and procedures for subsistence needs for staff and residents; - Policies and procedures to address needs for staff and residents whether evacuated or sheltered in place; - Policies and procedures for food, water, medical supplies and pharmaceutical supplies; - Policies and procedures for the	0 680		

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0 680	Continued From page 7 safe/sanitary storage of provisions; - Policies and procedures for tracking staff and patients; - Policies and procedures for medical documents; - Must develop a policy and procedure to maintain medical documentation the preserves resident information, protects confidentiality, and secures/maintains the availability of records; - Roles under wavier declared by secretary; - Policies and procedures for providing care and/or treatments at alternative care sites under 1135 waiver. The licensee's undated Emergency Management policy indicated the facility would have an identified plan in place to ensure the safety and well-being of residents and employees during periods of an emergency or a disaster that disrupts facility services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 700 SS=F	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by:	0 700		

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0 700	Continued From page 8 Based on observation, interview, and record review, the licensee failed to ensure personal health and medical information was kept private for three of three residents (R1, R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Unlicensed personnel (ULP)-B was hired December 1, 2023, to provide assisted living services. On October 21, 2024, from 12:01 p.m., to 12:07 p.m., the surveyor observed ULP-B provide medications to R1. ULP-B opened R-Tasks (an electronic charting system used for accessing resident records for medications and treatments) on the laptop computer screen. The screen displayed all the resident's identifying information and medications as well as access to all other residents residing within the facility. After using R-tasks to verify medications to be administered, ULP-B then went R1's room to administer medications. ULP-B did not return to the unlocked and unattended computer until 12:07 p.m. Upon return to the computer the surveyor observed ULP-B completed documentation of medication administration, followed by securing of the laptop. The surveyor observed two other staff and one resident pass directly by the unattended laptop.	0 700		

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0 700	Continued From page 9 On October 21, 2024, at 12:09 p.m., ULP-B stated they were trained to secure all resident information when using R-tasks, and they had failed to do so due to human error. On October 21, 2024, at 12:10 p.m., clinical nurse supervisor (CNS)-A stated the computer screen needed to be shut or closed when leaving the computer. The licensee's undated Resident Records policy indicated that all resident information shall be regarded as confidential and available to only authorized users. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 700		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or	0 780		

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0 780	Continued From page 10 sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that are interconnected so that the actuation of one alarm causes all alarms in the dwelling unit to actuate and failed to keep the facility in compliance with the Minnesota Fire Code. These deficient conditions had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On facility tour with the clinical nurse supervisor (CNS)-A on October 22, 2024, between 1:15 p.m. and 2:45 p.m. the following deficient condition was observed: SMOKE ALARMS:	0 780		

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0 780	Continued From page 11 The 120-volt smoke alarms in the facility shall be interconnected with the required battery-operated smoke alarms. The surveyor explained to the CNS-A that all smoke alarms in the facility shall be maintained and replaced with like type alarms including the 120-volt smoke alarms and that all smoke alarms shall be interconnected regardless of power supply. The deficient condition was visually verified by the CNS-A accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a	0 800		

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0 800	Continued From page 12 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On facility tour with the clinical nurse supervisor (CNS)-A on October 22, 2024, between 1:15 p.m. and 2:45 p.m. the following deficient condition was observed: BATHROOM SHOWER: The surveyor observed the caulking in the lower-level bathroom shower was in need of resealing and showed signs of mold. The surveyor explained to the CNS-A that the facility shall be kept in good repair and that the item noted above shall be fixed. The deficient condition was visually verified by the CNS-A accompanying on the tour. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping	0 810		

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0 810	Continued From page 13 rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 810		

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0 810	Continued From page 14 safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: A record review and interview were conducted on October 22, 2024, at approximately 2:15 p.m. with the clinical nurse supervisor (CNS)-A on the fire safety and evacuation plan and training for the facility. TRAINING: During record review the CNS-A stated they have not trained their employees on the fire safety and evacuation plan after new hire and that they have not offered the same training to the residents. The surveyor explained to the CNS-A that all employees shall be trained on the facilities specific fire safety and evacuation plan at new hire and twice a year thereafter and that this shall be documented. Also, the residents shall be offered the same training during intake and once a year thereafter and this shall be documented. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident	01620		

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01620	Continued From page 15 reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the RN conducted ongoing resident assessment and reassessment, not to exceed 90 calendar days from the last date of the assessment for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).	01620		

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01620	Continued From page 16 The findings include: R2 was admitted to the licensee and began receiving assisted living services on January 2, 2024. R2's diagnoses included diffuse traumatic brain injury without loss of consciousness, depression, intervertebral disc degeneration, gastro-esophageal reflux disease without esophagitis, anxiety disorder, adjustment disorder with mixed anxiety and depressed mood, insomnia, and tobacco abuse counseling. R2's Service Plan - Modification dated September 28, 2024, indicated R2 received assistance with ambulation, appointment reminder/assistance, bathing assistance, bedmaking, dressing, equipment care, grooming, housekeeping, incontinence care, laundry, behavior management, symptom management, meal assistance, medication administration, medication setup, nail care, vitals, safety check, shopping assistance, and socialization, R2's record contained 90-day assessments dated March 27, 2024, and June 29, 2024, which indicated that 94 days had passed between assessment dates. On October 23, 2024, clinical nurse supervisor (CNS)-A stated they had miscalculated the dates between assessments. The licensee's undated Nursing Assessment and Reassessment of Residents policy indicated ongoing reassessment and monitoring will be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last assessment.	01620		

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	40134	A. BUILDING: _____ B. WING _____	10/24/2024

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01620	Continued From page 17 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered	01730		

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01730	Continued From page 18 as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an individualized medication management record with the required content for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted to the licensee and began receiving assisted living services on July 16, 2024. R1's diagnosis included morbid obesity, hypercapnic, cognitive impairment, osteoarthritis, pre-diabetic, failure to thrive, hypertension, Afib, cirrhosis, debility, cyanosis, oxygen dependence,	01730		

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01730	Continued From page 19 lymphedema-bilateral legs, diabetic neuropathies-bilateral legs, dyslipidemia, acquired burn penis, adjustment disorder with depressed mood, congestive heart failure, right ventricular failure, persistent tachycardia, sleep apnea, acute hypoxemic respiratory failure, hypoxemia, and obstructive sleep apnea. R1's Service Plan - Modification dated October 15, 2024, indicated R1 received assistance with activities, appointment reminder/assistance, bathing assistance, bedmaking, compression stockings, dressing, equipment care, escort/mobility assistance, grooming, housekeeping, incontinence care, laundry, behavior management, symptom management, meal assistance, medication administration, medication setup, nail care, repositioning, vitals, safety check, shopping assistance, socialization, therapeutic exercises, and wound care. R2 R2 was admitted to the licensee and began receiving assisted living services on January 2, 2024. R2's diagnoses included diffuse traumatic brain injury without loss of consciousness, depression, intervertebral disc degeneration, gastro-esophageal reflux disease without esophagitis, anxiety disorder, adjustment disorder with mixed anxiety and depressed mood, insomnia, and tobacco abuse counseling. R2's Service Plan - Modification dated September 28, 2024, indicated R2 received assistance with ambulation, appointment reminder/assistance, bathing assistance, bedmaking, dressing, equipment care, grooming, housekeeping, incontinence care, laundry, behavior	01730		

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01730	Continued From page 20 management, symptom management, meal assistance, medication administration, medication setup, nail care, vitals, safety check, shopping assistance, and socialization. R1 and R2's medication management plan lacked the following required components: - specific written instructions for resident's medication administration; - medication management tasks that may be delegated to ULPs; - procedures for staff to notify an RN when problems arose; and - medication administration delegated to unlicensed personnel and documented resident specific instructions. On October 22, 2024, at 10:49 a.m., clinical nurse supervisor (CNS)-A provided the surveyor with an assessment completed on October 21, 2024, for R1 after initiation of the survey. CNS-A stated they had reviewed resident files and discovered there was missing information in the medication management plan for R1 and realized that information needed to be added. The licensee's undated Individualized Medication Management Plan and Record policy indicated the following: "The plan must include the following: a. A statement describing the medication management services that will be provided; b. Description of how medications will be stored, based on the resident's needs, risk of diversion and consistent with the manufacturer's directions; c. Documentation of specific resident instructions relating to the administration of medications; d. Identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis;	01730		

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01730	Continued From page 21 e. Identification of medication management tasks that may be delegated to unlicensed personnel; f. Procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services, and g. Any resident-specific requirements relating to documentation of medication administration, verifications that all medications are administered as prescribed and monitoring of medication use to prevent possible complications or adverse reactions." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
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 prescription medications were securely locked in a substantially constructed compartment and permitted only authorized personnel to have access. This had the potential to affect all residents in the facility. 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	01880		

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01880	Continued From page 22 resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On October 21, 2024, from 12:01 p.m., to 12:07 a.m., the surveyor observed unlicensed personnel (ULP)-B prepare medications for R1. The surveyor observed ULP-B retrieve medications from the locked medication cabinet using the facility's medications cart keys. After unlocking the cabinet, ULP-B left the medication cart keys unattended near the medication cabinet while administering medications to R1 from approximately 12:05 p.m., to 12:07 p.m. On October 21, 2024, at 12:09 p.m., ULP-B stated they typically put the medication cart keys in an upper wall cabinet after retrieving medications from the medication carts. ULP-B stated the medication cart keys were not secured on a person in between medication passes. On October 21, 2024, at 12:41 p.m., the surveyor observed the licensee utilized a kitchen base cabinet as a medication cart. The facility had a lock mounted to the cabinet doors, which were positioned below the cabinet drawers. The cabinet drawers were able to be removed for maintenance purposes which allowed for access into the locked lower cabinet compartment of the medication cart. The licensee's undated Medications Management Services policy indicated the RN will develop and update as needed specific procedures for controlling and storing medications including	01880		

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01880	Continued From page 23 controlled substances. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were maintained bearing the original prescription label with legible information for two of three residents (R2, R3) and failed to ensure time sensitive medications were labeled with the date opened for one of three residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	01890		

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01890	Continued From page 24 MEDICATION STORAGE On October 21, 2024, at 11:59 a.m., during an audit of the licensee's medication cart, the surveyor observed a medication cup containing medications stored outside of their original medications. Clinical nurse supervisor (CNS)-A stated the medications belonged to R2. CNS-A stated R2 had refused the medications the night prior and were saved in the medication cart to be offered the following night. The medication cup contained the following medications: - acetaminophen 500mg, 2 tablets; - gabapentin 300mg, capsule; - levetiracetam 750mg, 2 tablets; and - quetiapine 25mg. On October 21, 2024, at 12:20 p.m., the surveyor observed half of a small white pill in located in the back of the medication cart stored outside of the original packaging. CNS-A identified the medication as being Jardiance and stated it belonged to R3. CNS-A stated, "this medication had been discontinued months ago". TIME SENSITIVE MEDICATIONS On October 21, 2024, at 12:13 p.m., the surveyor observed an inhaler belonging to R2 stored in the licensee's medication cart. The inhaler was labeled as ANORO ELLIPTA (umeclidinium and vilanterol inhalation powder) 62.5mcg/25mcg. The manufacturer's instructions printed on the side of the box indicated to dispose of the inhaler six weeks after opening the moisture-protective foil tray or when the counter reads "0" (after all blisters have been used), whichever comes first. On October 22, 2024, 11:01 a.m., CNS-A stated they were responsible for managing the medication carts. Additionally, CNS-A stated that the medications that medications that had been	01890		

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01890	Continued From page 25 held, were not supposed to be. CNS-A stated there was a miscommunication between them and staff which resulted in the medications being saved. CNS-A stated staff were expected to immediately dispose of unused medications, and to document the refusal in the resident record. The licensee's Medication Management Services policy indicated the registered nurse (RN) is responsible for the implementation of the facilities medication management policies and procedures. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
02310 SS=D	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical or nursing standards for one of three residents (R1) who utilized hospital bed rails. Additionally, the licensee failed to provide care and services according to acceptable health care standards, medical, or nursing standards for one of one resident (R1) who utilized oxygen.	02310		

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02310	Continued From page 26 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1 was admitted to the licensee and began receiving assisted living services on July 16, 2024. R1's diagnosis included morbid obesity, hypercapnic, cognitive impairment, osteoarthritis, pre-diabetic, failure to thrive, hypertension, Afib, cirrhosis, debility, cyanosis, oxygen dependence, lymphedema-bilateral legs, diabetic neuropathies-bilateral legs, dyslipidemia, acquired burn penis, adjustment disorder with depressed mood, congestive heart failure, right ventricular failure, persistent tachycardia, sleep apnea, acute hypoxemic respiratory failure, hypoxemia, and obstructive sleep apnea. R1's Service Plan - Modification dated October 15, 2024, indicated R1 received assistance with activities, appointment reminder/assistance, bathing assistance, bedmaking, compression stockings, dressing, equipment care, escort/mobility assistance, grooming, housekeeping, incontinence care, laundry, behavior management, symptom management, meal assistance, medication administration, medication setup, nail care, repositioning, vitals, safety check, shopping assistance, socialization, therapeutic exercises, and wound care.	02310		

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02310	Continued From page 27 R1's 90-day assessment dated October 15, 2024, indicated R1 had a hospital bed which included half rails (bed rails) to assist with positioning and bed mobility. The assessment failed to indicate measurements of the bed safety zone, and instead indicated "The bed rail meets FDA guidelines." On October 21, 2024, at 11:41 a.m., during a tour of the facility the surveyor observed an oxygen tank stored in the upright position behind R1's bedroom door. On October 21, 2024, at 11:42 a.m., R1 stated the oxygen tank was full and was typically stored behind their bedroom door. On October 22, 2024, at 8:46 a.m., clinical nurse supervisor (CNS)-A stated they were unaware that oxygen tanks needed to be secured but would order storage rack for storing oxygen containers immediately. On October 22, 2024, 11:01 a.m., CNS-A stated they were unaware that hospital bed rails required documentation of measurements of the bed safety zones. The licensee's undated Use of Side Rails policy indicated the registered nurse (RN) is to assess whether the side rails meet FDA standards. The Food and Drug Administration's (FDA), A Guide to Bed Safety, dated 2000, and revised April 2010, indicated following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain,	02310		

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02310	Continued From page 28 uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) dated April 3, 2024, indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint. Additionally, the licensee must ensure the bed rail measurements are documented and that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendations." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Measurements - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements".	02310		

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02310	Continued From page 29 The licensee's undated Safe Oxygen Use and Storage policy indicated that containers must be secured in a stand or cart so they cannot be knocked over while in use or in storage and must not be in areas where they may be overturned due to a door opening or where they are in a pathway. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	02310		

Minnesota Department of Health

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

Type: Full
Date: *10/22/24*
Time: 11:00:00
Report: 1051241154

Food and Beverage Establishment Inspection Report

Location:
Abundant Homecare LLC
9524 Morgan Avenue North
Brooklyn Park, MN55443
Hennepin County, 27

Establishment Info:
ID #: 0041030
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/23

Operator:
Abundant Homecare LLC

Phone #:
ID #: 59402

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

The following orders were issued during this inspection.

4-300 Equipment Numbers and Capacities

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

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

AT TIME OF INSPECTION, THERE IS NO THIN-TIPPED THERMOMETER.
Comply By: 10/29/24

Food and Equipment Temperatures

Process/Item: Upright Cooler
Temperature: 41 Degrees Fahrenheit - Location: MILK
Violation Issued: No

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

MET WITH NURSE EVALUATOR, ZACHARY MORTH.

DISCUSSED THE FOLLOWING WITH JANET:

EMPLOYEE ILLNESS LOG
REPORTABLE ILLNESS AND SYMPTOMS
VOMIT CLEAN-UP PROCEDURE
THIN-TIPPED THERMOMETER

THE KITCHEN HAS MDF WOODEN CABINETS, LAMINATE COUNTERTOPS WITH HOLLOW BASES, SMOOTH TEXTURE CEILING, VINYL FLOORING, AND A NSF 184 DISHWASHER.

Type: Full
Date: *10/22/24*
Time: 11:00:00
Report: 1051241154
Abundant Homecare LLC

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1051241154 of 10/22/24.

Certified Food Protection Manager: Montunrayo J. Akinruli

Certification Number: FM108455 Expires: 11/12/27

Inspection report reviewed with person in charge and emailed.

Signed: _____
Janet

Signed: _____
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