Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF REMOVAL OF CONDITIONAL LICENSE

Electronic Delivery

December 12, 2024

Licensee
The Friendship Home Community
947 Lydia Drive West
Roseville, MN 55113

RE: License Number 415414
Health Facility Identification Number (HFID) 30530
Project Number(s) SL30530015

Dear Licensee:

On December 6, 2024, The Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed August 2, 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 December 12, 2024.**

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.

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
	30530	A. BUILDING: _____ B. WING _____	R 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FRIENDSHIP HOME COMMUNITY	947 LYDIA DRIVE WEST ROSEVILLE, MN 55113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments INITIAL COMMENTS: SL# SL30530015-2 On 11-5-24 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 10-10-24. At the time of the survey, there were six residents all of whom where receiving services under the Assisted Living license. As a result of the follow-up survey, the licensee is in substantial compliance.	{0 000}		
{0 510} SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by:	{0 510}	Not reviewed during this survey	
{0 690} SS=F	144G.43 Subdivision 1 Resident record (a) Assisted living facilities must maintain records for each resident for whom it is providing services. Entries in the resident records must be current, legible, permanently recorded, dated, and authenticated with the name and title of the	{0 690}		

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{0 690}	Continued From page 1 person making the entry. This MN Requirement is not met as evidenced by:	{0 690}	Not reviewed during this survey	
{0 700} SS=E	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}	Not reviewed during this survey	
{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:	{0 800}	Not reviewed during this survey	

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{0 810}	Continued From page 2	{0 810}		
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by:	{0 810}	Not reviewed during this survey	

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{0 810}	Continued From page 3	{0 810}		
{01910} SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by:	{01910}	Not reviewed during this survey	
{01940} SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current	{01940}		

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{01940}	Continued From page 4 individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by:	{01940}	Not reviewed during this survey	

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF CONDITIONAL LICENSE

Electronically Delivered

November 21, 2024

Licensee
The Friendship Home Community
947 Lydia Drive West
Roseville, MN 55113

RE: Conditional License Number 415414
Health Facility Identification Number (HFID) 30530
Project Number(s) SL30530015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a follow-up survey on October 10, 2024, for the purpose of assessing compliance with state licensing statutes. Based on the follow-up 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.20, MDH is issuing a 90-day conditional license due to expire on **February 19, 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 . . ."

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on August 2, 2024, found not corrected at the time of the October 10, 2024, follow-up survey and/or subject to penalty assessment are as follows:

0820 - Fire Protection And Physical Environment - 144g.45 Subd. 2 (g)

The details of the violations noted at the time of this follow-up survey completed on October 10, 2024 (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.

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 and immediately correct any reissued orders 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

CONDITIONAL LICENSE ISSUED:
MDH will issue The Friendship Home Community a conditional 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 The Friendship Home Community is in substantial compliance.

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

a. **Door Locking Hardware:** The Friendship Home Community, will replace the door locking hardware on the basement door leading from the living room to the exterior of the home.

RESULTS OF FOLLOW-UP EVALUATION DURING THE CONDITIONAL LICENSE PERIOD:
MDH will determine if The Friendship Home Community is in substantial compliance based on the results of the follow up survey. MDH will make this determination within the 90-day conditional license period. If MDH determines The Friendship Home Community is in substantial compliance on

the follow up survey, MDH will remove the conditions from The Friendship Home Community's assisted living facility license, and The Friendship Home Community will correct any outstanding violations identified during the survey. If The Friendship Home Community is not in substantial compliance on the follow-up survey, MDH may take additional enforcement action, up to and including immediate temporary suspension and revocation, as authorized by Minn. Stat. § 144G.20.

REQUESTING A HEARING:
Pursuant to Minn. Stat. §144G.20, Subd. 18, the licensee may appeal an action against the license under this section. The licensee must request a hearing no later than 15 business days after licensee receives notice of the action.

To submit a hearing request, please visit
https://forms.web.health.state.mn.us/form/HRD-Appeals-Form.

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 Tim Hanna directly at: 507-208-8982.

Sincerely,

Rick Michals

Rick Michals, J.D.
Executive Regional Operations Manager

Minnesota Department of Health
Health Regulation Division

JMD

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{0 000}	Initial Comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30530015-1 On October 1, 2024, through October 10, 2024, 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 August 2, 2024. At the time of the survey, there were six residents all of whom received services under the Assisted Living license. As a result of the follow-up survey, the following correction 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.	
{0 510} SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and	{0 510}		

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{0 510}	Continued From page 1 maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 510}		
{0 690} SS=F	144G.43 Subdivision 1 Resident record (a) Assisted living facilities must maintain records for each resident for whom it is providing services. Entries in the resident records must be current, legible, permanently recorded, dated, and authenticated with the name and title of the person making the entry. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 690}		
{0 700} SS=E	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	{0 700}		

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{0 700}	Continued From page 2 records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 700}		
{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: No further action required	{0 800}		
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or	{0 810}		

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{0 810}	Continued From page 3 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: No Further Action Required	{0 810}	No Further Action Required	
{0 820} SS=E	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the	{0 820}		

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{0 820}	Continued From page 4 commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure facility elements did not constitute a distinct hazard to life. This had the potential to directly affect more than a limited number of residents, staff, and employees. 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On October 10, 2024, at 10:35 a.m., during facility tour with licensed assisted living director (LALD)-D, survey staff observed in the basement a door with an exit sign leading from the living room to the exterior of the home. A key only lock was installed on this door above the door handle. The emergency floor plan labeled this door as an exit. The use of this type of door-locking hardware would limit the ability of occupants to safely exit the building in the event of an emergency. During the tour interview, LALD-D stated they understand the deficiancy and will remove the lock.	{0 820}		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{01940}	Continued From page 6 management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{01940}		

Electronically Delivered

September 4, 2024

Licensee
The Friendship Home Community
947 Lydia Drive West
Roseville, MN 55113

RE: Project Number(s) SL30530015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 2, 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 . . ."

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.

In accordance with Minn. Stat. § 144G.31, Subd. 4(a)(5), MDH may impose fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. MDH may impose a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. MDH also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

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

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

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

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
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

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. to submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: Jess.Schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30530	A. BUILDING: _____ B. WING _____	08/02/2024

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0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30530015-0 On July 29, 2024, through, August 2, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were five (5) residents receiving services under the provider's Assisted Living Facility license. On August 1, 2024, an immediate correction order was issued for tag identification 2310. The immediacy of the order was removed on August 2, 2024, based on supervisory review. 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.	
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and	0 510		

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0 510	Continued From page 1 maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain an effective infection control program to comply with acceptable health care, medical, and nursing standards for infection control for two of two unlicensed personnel ((ULP)-B, ULP-E) while performing personal cares. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: GLOVES/HAND HYGIENE On July 30, 2024, from 9:16 a.m. through 9:35 a.m., the surveyor observed ULP-B and ULP-E enter R4's room, apply gloves, close window shades and bedroom door. Both ULPs assisted with undressing R4 which left R4 completely	0 510		

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0 510	Continued From page 2 naked and exposed. ULP-E then proceeded to wash R4's face while ULP-B began providing perineum care without informing R4. Once ULP-E was done washing R4's face, she then covered R4's top half of the body. ULPs proceeded to finish perineum care, then rolled R4 to the right side to apply a skin protectant barrier cream to the buttocks and ULP-E removed soiled incontinent brief and replaced with a clean brief. After perineum care, the surveyor observed ULP-B remove dirty gloves and apply new gloves without hand hygiene (HH), but surveyor did not observe ULP-E change gloves or perform HH after wiping and applying barrier cream. With dirty gloves, ULP-E assisted ULP-B with dressing R4, positioning R4 in bed by placing pillows under both legs, and boosting R4 up toward the head of the bed. With same dirty gloves, ULP-E grabbed the bed remote and adjusted the head of the bed and placed the remote directly into R4's hands. ULP-E then removed gloves before opening the window shades, went into laundry room, then upstairs where she washed her hands. ULP-E's Personal Protective Equipment (PPE)-House Manager/Supervisory Staff skill competency signed by a manager on October 17, 2022, read ULP-E was competent on correct procedure of performing hand hygiene after removing gloves. ULP-E's Personal Cares-House Manager and/or Supervisor skill competency signed by a manager on October 17, 2022, read after washing the buttocks, dry the area, then remove gloves and wash hands. Re-apply clean gloves and replace new brief. On July 30, 2024, at 2:18 p.m., ULP-E stated she was trained to start cleaning a resident from top	0 510		

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0 510	Continued From page 3 bottom, perform perineum care, take off gloves and wash hands. ULP-E stated she would double glove but did not do that during the surveyor's observation. IMPROPER WIPING On July 30, 2024, at 1:00 p.m., the surveyor observed ULP-B and ULP in training (ULP)-F transfer R5 from Broda chair (oversized padded chair) into bed using a mechanical lift. ULP-B explained to R5 they were going to assist with a brief change. ULP-B performed perineum care of the front by wiping front to back then ULP-F assisted R5 by turning her body to the left side. R5 had a bowel movement (BM) so ULP-B began wiping back to front which brought the BM toward the vagina. ULP-B wiped back to front four times total while ULP-F was watching. ULP-B and ULP-F finished cares and placed R5 back into the Broda chair. ULP-B's Skill Competency Personal Cares signed by registered nurse (RN)-A on December 6, 2023, read under "Female Peri-Care," wash perineal area with washcloth, soap, and warm water moving from front to back and dry thoroughly from front to back. On July 30, 2024, at 1:18 p.m., ULP-B stated she wiped from back to front because she had already wiped the front side when the resident was on her back. ULP-B did recognize she wiped from back to front. On July 30, 2024, at 1:27 p.m., RN-A stated staff were trained to remove gloves and perform HH before they leave the room, no gloves in the hallway. Unlicensed staff were also trained to remove gloves and perform HH after personal cares. RN-A stated for women, staff should be	0 510		

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0 510	Continued From page 4 wiping front to back using a clean wipe each time they wipe. The licensee's 8.07 Gloves procedure dated August 1, 2021, read the following: wash hands, apply gloves to both hands, remove contaminated materials, place materials in proper receptacle, remove gloves, dispose used gloves in proper receptable, and rewash hands. The licensee's 6.29 Toileting Assistance procedure dated August 1, 2021, read staff should always wipe from front to back and allow resident to clean self if able. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 690 SS=F	144G.43 Subdivision 1 Resident record (a) Assisted living facilities must maintain records for each resident for whom it is providing services. Entries in the resident records must be current, legible, permanently recorded, dated, and authenticated with the name and title of the person making the entry. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure resident bed rail entrapment zone measurements were authenticated with the name and title of the person who completed the measurements and failed to ensure the record was permanently recorded with the date they were completed for four of four residents (R2, R3, R4, R5).	0 690		

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0 690	Continued From page 5 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 July 30, 2024, at 1:27 p.m., the surveyor requested bed rail zone measurements for each resident. Registered nurse (RN)-A stated the initial bed rail assessment (electronic health record program) allowed an area to input zone measurements, but the monthly bed rail checklist did not. RN-A stated she may have documented those measurements within the resident's progress notes but would try to locate them. On July 31, 2024, at 12:18 p.m., RN-A provided two photos. Photo one had the following handwritten information: [licensee] bed rails-March, first name of R2, R3, R4, and R5 and next to each name where numbers 1-4 which had a measurement in inches next to it. Photo two had the following information: [licensee] bed rails-June, first name of R2, R3, R3, R5 and next to each name where numbers 1-4, which had a measurement in inches next to it. R2, R3, R4, and R5 were admitted to licensee for services on December 19, 2023, December 13, 2022, May 11, 2022, and April 4, 2016, respectively. R2, R3, R4, and R5's medical records lacked the	0 690		

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0 690	Continued From page 6 signature and title of the person documenting, full date, and full resident name. This handwritten document was not permanently located in each resident's record. The licensee's 2.37 Resident Record-Documentation policy dated August 1, 2021, indicated staff of [licensee] authorized to document in a resident record will do so for all medications, services, treatments, and therapies for each resident. Staff will also document other important and pertinent information relating to each resident. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 690		
0 700 SS=E	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: Based on observation, interview, and record review, the licensee failed to ensure two of two resident's (R5, R3) personal health and medical information were kept private. This practice resulted in a level two violation (a	0 700		

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0 700	Continued From page 7 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On July 30, 2024, at 8:38 a.m., the surveyor observed unlicensed personnel (ULP)-E sit down at a desk against the wall in the eating area of the kitchen (near the front door) which had a large computer monitor facing the eating area. ULP-E set up R5's medications at the desk next to the monitor and put the remaining medications back into the cabinet. ULP-E went to administer the medications to R5 who was seated in the dining room adjacent to the kitchen leaving R5's medical record open on the computer screen. A few minutes later, ULP-E washed her hands and went to the computer to document the medication administration. At 8:45 a.m., right after the last medication administration, ULP-E repeated the same process for R3's medications. After putting the remaining medications back into the cabinet, ULP-E left R3's medical record on the computer screen then brought the medications downstairs to R3's room to administer. ULP-E came back upstairs, washed hands, and documented on the computer then logged off. On July 30, 2024, at 1:27 p.m., registered nurse (RN)-A stated staff should minimize and lock the screen every time they walk away from the computer. RN-A stated they use to have a laptop which was kept directly in the kitchen and out of	0 700		

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0 700	Continued From page 8 direct view but after change of ownership, the current licensee began using a different electronic health record program and moved the medication set up area into the eating area of the kitchen. On July 30, 2024, at 2:18 p.m., ULP-E stated her process was normally to minimize the screen in between resident medication passes then once the medication administration task was done, she would save and log off the electronic health program. ULP-E's Confidentiality Agreement signed October 6, 2022, indicated the following, "I agree that all documents, including but not limited to, chart information, medication records, financial data, communication logs, and any information transmitted via telephone, fax, mail, electronic mail, or electronic health record must be carefully safeguarded and released only to management personnel and any authorized person on a need-to-know basis." The licensee's 2.35 Resident Record-Access & Storage policy dated August 1, 2021, indicated resident records will be kept confidential and locked in a secured area where only authorized staff of the [licensee] will have access. The policy also indicated the following: -all information in the resident record is confidential; all staff are responsible to make sure confidentiality is maintained for all resident records and information; and -fax machines or computers used to receive resident information will be kept in areas accessible to authorized staff only. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 700		

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0 700	Continued From page 9 (21) days	0 700		
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 provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive 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 July 30, 2024, at 10:35 a.m., survey staff toured the home with licensed assisted living director (LALD)-D. During the tour, survey staff observed the following: 1. The basement emergency floor plan labeled an	0 800		

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THE FRIENDSHIP HOME COMMUNITY	947 LYDIA DRIVE WEST ROSEVILLE, MN 55113

(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	Continued From page 10 exit route through the furnace room and then into an office. The floor plan for the main level of the home identified an exit route with red arrows leading to the door for the attached garage. Emergency exits are required to lead directly to the exterior of the building and not through a higher hazard room. During the facility tour interview, LALD-D stated the office exit door was for employees and the door leading into the attached garage was not designated as an exit. LALD-D verified the exit routes on the floor plan required revision. 2. In resident bedroom 6, an extension cord was used and there was a hole in the closet door. Extension cords must not be used as a substitute for permanent wiring and all resident facilities properly maintained. During the facility tour interview, LALD-D verified the extension cord required removal and the closet door needed repair. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique	0 810		

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0 810	Continued From page 11 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 record review and interview, the licensee failed to develop a 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 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:	0 810		

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0 810	Continued From page 12 On July 30, 2024, the licensed assisted living director (LALD)-D provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and employee evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. Four residents were identified as non-ambulatory and required assistance during an evacuation. During an interview on July 30, 2024, at 12:45 p.m., LALD-D verified procedures for these residents were not included in the FSEP. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 820 SS=E	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction.	0 820		

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0 820	Continued From page 13 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure facility elements did not constitute a distinct hazard to life. This had the potential to directly affect more than a limited number of residents, staff, and employees. 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On July 30, 2024, at 10:35 a.m., during facility tour with licensed assisted living director (LALD)-D, survey staff observed in the basement a door with an exit sign leading from the living room to the exterior of the home. A key only lock was installed on this door above the door handle. The emergency floor plan labeled this door as an exit. The use of this type of door-locking hardware would limit the ability of occupants to safely exit the building in the event of an emergency. During the tour interview, LALD-D stated the key only lock was not used, the licensee did not have a key, and when this door needed to be locked, employees used the lock installed on the door handle. LALD-D verified the key only lock required removal. TIME PERIOD FOR CORRECTION: Two (2)	0 820		

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0 820	Continued From page 14 days	0 820		
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to complete documentation in the resident's record regarding the disposition of medication to include the medication strength, prescription number, quantity, to whom the medications were given, date of disposition, and names of staff involved in the disposition for one of one discharged resident (R1) and two of two current residents (R3, R4). This practice resulted in a level two violation (a	01910		

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01910	Continued From page 15 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 July 29, 2024, at 10:10 a.m., during entrance conference, registered nurse (RN)-A and licensed assisted living director (LALD)-B stated the licensee provided medication management to all residents. R1 R1's start of care with the licensee was June 18, 2022, and discharge date was June 4, 2024. R1's Discharge Summary completed by RN-A on June 5, 2024, indicated R1 was admitted to the hospital on May 28, 2024, for aspiration pneumonia and constipation. R1 later passed away at the hospital. The discharge summary also indicated the licensee administered R1's medications and disposed of the medications. R1's Medication Disposition Log dated July 18, 2024, listed the following medications destroyed: hydroxyzine 10 milligrams (mg) and 50 mg, calcium 600 mg, simvastatin 20 mg, gabapentin 300 mg, mirtazapine 15 mg, Certavite tabs, escitalopram 20 mg, losartan potassium 25 mg, oxybutynin 10 mg, baclofen 5 mg, and methylphenidate 5 mg (schedule II substance). The medication disposition log lacked a prescription number for each medication.	01910		

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01910	Continued From page 16 R3 On July 30, 2024, at 8:45 a.m., unlicensed personnel (ULP)-E set up and administered the following medications from a pharmacy bubble pack (each pill goes into a bubble slot) to R3: baclofen 20 mg, bupropion 150 mg, Januvia 100 mg, lisinopril 5 mg, oxybutynin 5 mg, oyst-cal/D 500 mg/200 units (u), citalopram 20 mg, Senexon-S 8.6-50 mg, and vitamin D3 25 microgram (mcg). R3's start of care with the licensee was December 13, 2022. R3's Nursing Assessment dated June 13, 2024, indicated R3 required assistance with medication management. R3's service plan signed on December 29, 2022, read R3 received medication administration daily by ULP's. R3's Medication Disposal Log dated March 7, 2024, listed the following medications destroyed: baclofen 20 mg, bupropion 150 mg, citalopram 20 mg, Januvia 100 mg, lisinopril 5 mg, oxybutynin 5 mg, oyst-cal/D (no dose listed), vitamin D3 (no dose listed), atorvastatin 10 mg, and pramipexole (no dose listed). The medication disposition log lacked a dose for three medications and prescription numbers for each medication. R4 R4's start of care with the licensee was May 11, 2022. R4's Nursing Reassessment dated May 1, 2024, indicated R4 required assistance with medication management.	01910		

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01910	Continued From page 17 R3's service plan signed June 2, 2022, read R3 was fully dependent on medication administration daily by ULPs. R3's Medication Disposal Log dated March 7, 2024, listed the following medications destroyed: amlodipine 10 mg, haloperidol 10 mg, sulfasalazine 500 mg, olanzapine 10 mg, acetaminophen 325 mg, and trazadone (no dose). The medication disposition log lacked a dose for trazodone and prescription numbers for each medication. On July 31, 2024, at 1:08 p.m., by email, RN-A indicated the medication disposition log provided was the only log they used for all medication disposals. The licensee's 7.23 Medication Disposal policy dated August 1, 2021, read 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 disposal of medications and controlled substances. The policy also read: -"Unused Prescription Drugs: 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;" -"Unused Controlled Substances: upon disposition, the facility must document in the resident's record the disposition of the expired medication including the medication's name, strength, prescription number as applicable, quantity, date of disposition, and names of staff	01910		

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01910	Continued From page 18 (including a witness) and other individuals involved in the disposition." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must	01940		

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01940	Continued From page 19 be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an individualized treatment and therapy management plan was developed with all the required information for one of one resident (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R4's start of care with licensee was May 11, 2022, and diagnoses included schizophrenia, rheumatoid arthritis, and functional quadriplegia/ambulatory dysfunction/physical deconditioning. R4's unsigned Service Agreement last revised on June 14, 2022, indicated R4 received assistance with dressing and grooming, bathing, toileting, nail care, one-on-one activity, bed mobility, behavior management, mobility dependence, and medication and treatment administration. R4's service plan lacked a written statement of the treatment services that would be provided to the resident. On July 30, 2024, from 9:16 a.m. through 9:35	01940		

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01940	Continued From page 20 a.m., the surveyor observed unlicensed personnel (ULP)-B and ULP-E perform a bed bath and perineum care to R4. While R4 was rolled to her right side, exposing her buttocks, the surveyor observed a pencil eraser tip size sore on both buttocks which appeared to be stage two pressure ulcer (a break in the top two layers of skin). ULP-E wiped the ulcers to remove paste and reapplied white barrier paste to those areas. R4's treatment plan completed by licensed assisted living director (LALD)-D and assessed by registered nurse (RN)-A on May 15, 2024, read wound care was delegated to ULPs. R4's provider orders dated March 18, 2024, ordered homecare skilled nursing for evaluation and treatment of stage two pressure ulcer to buttocks. R4's Medication Administration Record (MAR) dated July 1-30, 2024, indicated ULP-B, ULP-E ULP-G, ULP-H, and ULP-I all initialed for the following service: "Remove old dressing, clean with wound cleanser and pat dry. Apply Triad paste (promotes healing) to wound bed. Cover with Mepilex (foam bandage), date and initial. Chart on progress note on above dressing change. change dressing as needed (PRN) if soiled. Ok to shower. Encourage off loading pillow DATE AND INITIAL mepilex [sic]. OK to change if soiled." R4's medical record lacked any progress notes by ULPs indicating they changed R4's Mepilex bandage. On July 30, 2024, at 9:35 a.m., the surveyor asked ULP-E if R4 was supposed to have the Mepilex bandage and ULP-E stated "no, just the	01940		

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01940	Continued From page 21 cream because it is better to let the buttock air out." ULP-E also stated the wound to buttock occurred on and off. On July 30, 2024, at 1:27 p.m., RN-A stated R4 required the Triad paste, but insurance would not cover the Mepilex bandage because the wound was healing. RN-A then stated she would change the Mepilex bandage to as needed (PRN). No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
02310 SS=F	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 two of four residents (R4, R2) with hospital bed rails. 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	02310		

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02310	Continued From page 22 of the residents). The findings include: On July 29, 2024, at approximately 10:58 a.m., during a facility tour, the surveyor observed upper half bed rails on both sides of R4 and R2's hospital beds. R4 R4's diagnoses included delusional disorders, schizophrenia, and paranoid schizophrenia. R4's unsigned Service Agreement last revised on June 14, 2022, indicated R4 received assistance with dressing and grooming, bathing, toileting, nail care, one-on-one activity, bed mobility, behavior management, mobility dependence, and medication and treatment administration. On the service agreement under service type "Mobility: dependence-Notes: {Siderail} (Ensure that the side rails is tight to bed. Hospital electric bed, manual W/C, Hoyer lifted chair. If loose notify [licensed assisted living director [LALD]-A]." R4's Appendix 3: Monthly Bed Rail Checklist signed by registered nurse (RN)-A on July 12, 2024, read "yes" staff have been provided with suitable information, instruction, training, and supervision for the type of bed rail in use and "yes" that the bed rails continued to be fitted correctly, secured, and rigid and close to the mattress. R4's Service Received documentation dated July 2024, under "Mobility: dependence" it was initialed by staff for the following: -July 28, 2024, at 8:00 a.m.-unlicensed personnel (ULP)-H; -July 29, 2024, at 8:00 a.m.-ULP-G; and	02310		

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THE FRIENDSHIP HOME COMMUNITY	947 LYDIA DRIVE WEST ROSEVILLE, MN 55113

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02310	Continued From page 23 -July 30, 2024, at 8:00 a.m.-ULP-E. On July 30, 2024, at 9:16 a.m., during morning cares while in bed, the surveyor observed both bed rails raised on R4's bed. The surveyor observed both bed rails to be wobbly by rocking back and forth and could easily be pulled away from the bed a few inches. On July 30, 2024, at 1:18 p.m., ULP-B stated she had been trained to notify the nurse if a bed rail was wobbly, but she did not tighten the bed rails herself. ULP-B said someone would come out and tighten them. On July 30, 2024, at 1:27 p.m., during phone interview, RN-A stated for monthly bed rail checks, she visualized the bed, checked the mattress for gaps and made sure the bed rails were secured to the bed frame. On July 30, 2024, at 2:18 p.m., ULP-E stated R4's bed rails became "wobbly" more frequently due to constant use of the bed rails for positioning while in bed. ULP-E stated when that happens, staff notify the maintenance person. R2 R2's diagnoses included lung transplant status, chronic kidney disease, pressure ulcer of right ankle (stage 3), and intra-abdominal hernia. R2's unsigned Service Agreement last revised on March 14, 2024, read R2 received assistance with dressing and grooming, toileting, transfers with mechanical lift, wheeling, bathing, positioning, medication and treatment administration, mental health, laundry, meal assistance, and housekeeping.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30530	A. BUILDING: _____ B. WING _____	08/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FRIENDSHIP HOME COMMUNITY	947 LYDIA DRIVE WEST ROSEVILLE, MN 55113

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02310	Continued From page 24 R2's Appendix 3: Monthly Bed Rail Checklist signed by RN-A on July 19, 2024, read "yes" staff have been provided with suitable information, instruction, training, and supervision for the type of bed rail in use and "yes" that the bed rails continued to be fitted correctly, secured, and rigid and close to the mattress. On July 31, 2024, at 10:35 a.m., ULP-G and the surveyor observed bilateral upper half bed rails on R2's hospital style bed. Both bed rails were not secured to the bed (rocked back and forth and were able to pull away from the bed a few inches). ULP-G immediately tightened both bed rails which became more secured. ULP-G stated sometimes ULP trainees turn the knob of the bed rail thinking it will either lower or raise the bed rail which can loosen the bed rails. ULP-G also said when the maintenance person came to tighten the bed rails, it made them even more secure. ULP-B and ULP-E's Siderails training dated December 5, 2023, and August 8, 2022, respectively, read the differences of adult portable bed rails and hospital bed rails, areas of entrapment, falls related to bed rail use, potential benefits of bed rail use, risks with bed rail use, and the training references the Food and Drug Administration's (FDA) for bed rail guidance, and the responsibility of the licensee related to bed rails. On August 1, 2024, at 9:48 a.m., ULP-G stated for documentation under R4's service "mobility: dependence," she was charting that she has checked the bed rail for tightness and that mobility assistance has occurred or been offered. ULP-G would then chart whether R4 stayed in bed or was transferred into a chair or wheelchair. ULP-G would also chart in the progress notes if	02310		

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02310	Continued From page 25 LALD-A was contacted regarding the bed rail. ULP-G stated she had contacted LALD-A once a while ago regarding R1's bed rail which required maintenance of the actual bed. ULP-G stated she doesn't come across R2's bed rails being that loose like observed but once every few weeks and she will tighten them herself. ULP-G then explained R2 and R4 used their bed rails more frequently than others which causes the bed rails to loosen more often. ULP-G again explained new hire trainees often loosen the bed rail by turning the knob and she will then train them on how to operate the bed rail properly. On August 1, 2024, at 10:29 a.m., RN-A explained when new hire trainees begin shadowing another ULP for the shift, they don't receive any training beforehand. They typically shadow 3-5 days then the trainee would begin online training on Eldermark (an online training platform) which typically lasts between one to two weeks. Once online training is completed, RN-A would meet with trainee to test out on skills and medication administration, then the trainee would shadow again and do a final test out before they were on their own. RN-A stated during bed rail training, she goes over how to operate the bed rail, how to tighten them, and who to notify for issues related to bed rails. RN-A stated LALD-A handles the maintenance of the bed rail and she should be contacted if there were issues related to the bed itself. After record review, interviews, and observations, it was unclear to the surveyor why R2 and R4's bed rails were loose, and who, if anyone, was notified. The licensee's 6.28 Side Rails Policy dated August 1, 2021, read, " POLICY: When [licensee]	02310		

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	30530	A. BUILDING: _____ B. WING _____	08/02/2024

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02310	Continued From page 26 is aware a home care resident is utilizing side rails (a medical device) on a bed, [licensee] will assess the use, educate the resident, and when appropriate, the responsible person, regarding the risks and benefits of side rails, and verify that the side rail in use is of a safe design and utilized consistent with the manufacturer's directions. This policy shall be followed regardless of who owns or is supplying the side rail." The policy also read, "PROCEDURE-VERIFY THE MEDICAL DEVICE IS SAFE: b. The side rails are installed securely and maintained in good operating condition. Be aware of "wobbly" side rails. C. The side rail design is consistent with FDA's 2006 recommended dimensional measurements to reduce entrapment. This means side rail zones 1, 2, and 3 must not exceed 4.75 [inches]." 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." Also included, documentation about a resident's hospital bed rail should include, 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	02310		

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02310	Continued From page 27 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. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate The immediacy of the order was removed on August 2, 2024, based on supervisory review. Noncompliance remained and the scope and level remain unchanged.	02310		

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

Type: Full
Date: *07/29/24*
Time: 12:21:48
Report: 8058241178

Food and Beverage Establishment Inspection Report

Location:

The Friendship Home Community
947 Lydia Drive West
Roseville, MN55113
Ramsey County, 62

Establishment Info:

ID #: 0037800
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6513982294
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.

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Hot Water: = at 160 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: DELI TURKEY
Temperature: 41 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

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

HRD INSPECTOR ANNA BOHNEN

RESIDENTIAL HOME WITH NON COMMERCIAL APPLIANCES AND FINISHES

Type: Full
Date: *07/29/24*
Time: 12:21:48
Report: 8058241178
The Friendship Home Community

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 8058241178 of 07/29/24.

Certified Food Protection Manager: FAIZA HASSAN

Certification Number: 108405 Expires: 09/26/24

Inspection report reviewed with person in charge and emailed.

Signed: _____
Establishment Representative

Signed: _____
Aaron Gertz
Sanitarian 3
MDH Metro Office
651 201 4500
health.foodlodging@state.mn.us