Electronically Delivered

January 10, 2024

Licensee
Arthur's Senior Care
3310 Emmert Street
Roseville, MN  55126

RE: Project Number(s) SL27856015

Dear Licensee:

On December 29, 2023, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the September 22, 2023, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Jessie Chenze, Supervisor
State Evaluation Team
Email: jessie.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

HHH

Electronically Delivered

October 23, 2023

Licensee
Arthur's Senior Care
3310 Emmert Street
Roseville, MN  55126

RE:  Project Number(s) SL27856015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on September 22, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the 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.

**STATE CORRECTION ORDERS**

The enclosed State Form documents the state correction orders. The 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), the MDH may impose fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment.
The 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. The 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 - 2320 - 144g.91 Subd. 4 (b) - Appropriate Care And Services - $3,000.00**

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,000.00**. You will be invoiced 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 the MDH within 15 calendar days of the correction order receipt date.

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

**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 MDH within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. Requests for hearing may be emailed to: **Health.HRD.Appeals@state.mn.us**.

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

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 |
|---|---|---|---|
| | 27856 | A. BUILDING: _____ B. WING _____ | 09/22/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARTHUR'S SENIOR CARE | 3310 EMMERT STREET ROSEVILLE, MN 55126 |

| (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 |
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| 0 000 | Initial Comments<br><br>******ATTENTION******<br><br>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.<br><br>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.<br><br>INITIAL COMMENTS:<br>SL27856015-0<br><br>On September 18, 2023, through September 22, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were six active residents whom were receiving services under the Assisted Living with Dementia Care license.<br><br>The immediacy of order 2320 was removed on September 22, 2023, based on supervisory review. The scope and level remain unchanged. | 0 000 | Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction.<br><br>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.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3. | |
| 0 510 SS=E | 144G.41 Subd. 3 Infection control program<br><br>(a) All assisted living facilities must establish and maintain an infection control program that | 0 510 | | |

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| 0 510 | Continued From page 1<br><br>complies with accepted health care, medical, and nursing standards for infection control.<br>(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.<br>(c) The facility must maintain written evidence of compliance with this subdivision.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program to comply with accepted health care, medical and nursing standards for infection control for two of two unlicensed personnel ((ULP)-B, ULP-G) observed to provide personal cares and medication administration to residents.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).<br><br>The findings include:<br><br>During observation on September 19, 2023, at 9:07 a.m., both ULP-B and ULP-G entered R3's room, closed the door and ULP-B and ULP-G donned (applied) gloves. ULP-G applied lotion to | 0 510 | | |

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| 0 510 | Continued From page 2<br><br>R3's legs while ULP-B removed R3's soiled brief, provided perineum care after a bowel movement (BM). ULP-B did not doff (remove) soiled gloves and applied a clean brief and assisted ULP-G with pulling up pants. ULP-B applied a sling underneath R3 while ULP-G turned R3 on her left side. ULP-B then doffed gloves, placed in trash, then removed trash from trash can and opened the door to exit. No hand hygiene was completed by ULP-B within the apartment. ULP-G then doffed gloves and transferred R3 from bed to the Broda chair (reclining chair with cushions) using an electric mechanical lift (full body lift with sling). Once in Broda chair, ULP-G donned gloves without performing hand hygiene and began performing oral care.<br><br>During observation on September 19, 2023, at 9:48 a.m., ULP-B washed hands and set up R2's medications on the kitchen counter. Upon entry of R2's room, ULP-B did not perform hand hygiene. Without donning gloves, ULP-B sat next to R2's bed where R2 was lying down and inserted an extension tube (tube for liquid to pass into the stomach) to R2's Mic-key button (gastrostomy-stomach opening). ULP-B administered medications through the extension tube, once completed, with bare hands, removed the gauze that was placed between the skin and the Mic-key button (gauze would absorb any gastric drainage), and placed it on the plate where the other equipment was kept. ULP-B exited room, walked to kitchen with the plate, placed the gauze on the kitchen countertop and placed the dishes into the dishwasher, threw away the gauze then washed hands. Surveyor did not observe any disinfecting of the countertop immediately after.<br><br>ULP-B's Feeding Use and Bolus RN Test Out | 0 510 | | |

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| 0 510 | Continued From page 3<br><br>competency dated April 4, 2023, indicated prior to administering medications via gastrostomy tube, the ULP must apply gloves.<br><br>During interview on September 19, 2023, at 2:16 p.m., ULP-B stated she/he usually "double gloved" and removed the soiled glove and would have a clean one on for continued cares, "so BM wouldn't get all over." When asked if hand hygiene occurred in between tasks with the same resident, ULP-B stated, "not particularly," she/he didn't wash hands in between gloves because gloves were worn.<br><br>Clinical nurse supervisor (CNS)-F was not available for interview.<br><br>The licensee's 8.07 Gloves policy dated August 1, 2022, indicated staff to wash hands, apply gloves to both hands, remove contaminated materials, place materials in proper receptacle, remove gloves and place in proper receptacle, and rewash hands.<br><br>The licensee's 8.09 Hand washing policy dated August 1, 2022, indicated proper hand washing techniques should be used between tasks and after bathroom use to prevent cross contamination. The policy also indicated proper hand hygiene should be completed before applying gloves and after removing gloves.<br><br>The licensee's 8.05 Disinfecting Environmental Surfaces policy dated August 1, 2022, indicated good infection control practices mandates that environmental surfaces be kept clean and free from contamination.<br><br>No further information was provided. | 0 510 | | |

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| 0 510 | Continued From page 4<br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 510 | | |
| 0 650 SS=F | 144G.42 Subd. 8 Employee records<br><br>(a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information:<br>(1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules;<br>(2) records of orientation, required annual training and infection control training, and competency evaluations;<br>(3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision;<br>(4) documentation of annual performance reviews that identify areas of improvement needed and training needs;<br>(5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and<br>(6) documentation of the background study as required under section 144.057.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure the employee record contained the required content to include an annual performance evaluation for one of one employee (clinical nurse supervisor (CNS)-F). Additionally, the licensee failed to provide evidence of demonstrated competency | 0 650 | | |

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| 0 650 | Continued From page 5<br><br>for two of two unlicensed personnel ((ULP)-B, ULP-G) using mechanical lifts (a device that lifts a resident using full body sling).<br><br>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).<br><br>The findings include:<br><br>ANNUAL PERFORMANCE REVIEW<br>CNS-F had a hire date of October 1, 2014.<br><br>CNS-F's employee record lacked performance evaluations.<br><br>During interview on September 21, 2023, at 3:18 p.m., director of housing and services (DHS)-D stated annual performance reviews were not completed for CNS-F.<br><br>EVIDENCE OF DEMONSTRATED COMPETENCY<br>ULP-B had a hire date of December 13, 2022, to provide direct care to residents.<br><br>ULP-G had a hire date of July 12, 2023, to provide direct care to residents.<br><br>ULP-B and ULP-G's training records lacked evidence of demonstrated competency on mechanical lifts.<br><br>During observation on September 19, 2023, at | 0 650 | | |

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| 0 650 | Continued From page 6<br><br>9:12 a.m., ULP-G transferred R3 from bed to Broda chair (reclining chair with cushions) using an electric mechanical lift.<br><br>During observation on September 19, 2023, at 10:28 a.m., ULP-B transferred R2 from bed to shower chair using a manual mechanical lift.<br><br>During interview on September 11:14 a.m., ULP-G stated during orientation training, she/he did not do a return demonstration to the nurse. ULP-G stated they did demonstrations with house manager (HM)-E on site and did a test out.<br><br>During interview on September 12:24 p.m., ULP-I stated they watched a video on mechanical lifts, then was shown by the nurse how to use the mechanical lift and in return ULP-I explained to RN step by step what to do. ULP-I stated the return demonstration was not done with a person. ULP-I did the mechanical lift transfer with a resident on site with staff.<br><br>During interview on September 21, 2023, at 1:30 p.m., registered nurse case manager (RNCM)-A indicated they checked with the director of nursing regarding evidence of demonstrated competency on mechanical lifts and they could not provide documentation for any staff trained. RNCM-A stated all staff were trained on mechanical lifts at orientation training but there wasn't a location to document mechanical lifts on their current competency form. RNCM-A stated they would be adding a place to document mechanical lifts on the form going forward.<br><br>The licensee's 4.05 Employee Records policy indicated employee records for each person would include documentation of annual performance reviews that identify areas of | 0 650 | | |

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| 0 650 | Continued From page 7<br><br>improvement needed and training needs. The policy also indicated employee records would include verification of completed orientation and annual training and competency testing as required.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 0 650 | | |
| 0 680 SS=F | 144G.42 Subd. 10 Disaster planning and emergency preparedness<br><br>(a) The facility must meet the following requirements:<br>(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;<br>(2) post an emergency disaster plan prominently;<br>(3) provide building emergency exit diagrams to all residents;<br>(4) post emergency exit diagrams on each floor; and<br>(5) have a written policy and procedure regarding missing residents.<br>(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.<br>(c) The facility must meet any additional requirements adopted in rule. | 0 680 | | |

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| 0 680 | Continued From page 8<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review the licensee failed to have a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all residents receiving services under the assisted living with dementia license. Additionally, the licensee failed to post an emergency disaster plan prominently.<br><br>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).<br><br>The findings include:<br><br>During observation on September 18, 2023, at 12:50 p.m., surveyor could not locate the EPP. Director of housing services (DHS)-D stated the EPP was available on SharePoint (online document platform) and did not have a physical copy available. DHS-D pointed out a one-page document labeled "A. Emergency Procedures" in case of a fire, tornado, and healthcare emergency. The document was on the right side of the refrigerator facing a window which was not accessible to anyone but staff.<br><br>The licensee's Emergency Response, Reporting and Review Policy and Plan dated August 1, 2021, did not include the following required content: | 0 680 | | |

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| 0 680 | Continued From page 9<br>- establish and maintain a comprehensive EPP, (reviewed/updated annually);<br>- how they would coordinate with other health care facilities and community during an emergency or disaster (natural, man-made, facility, etc.), (reviewed/updated annually);<br>- documented date of reviews and updates;<br>- community risk assessment with documentation;<br>- consider duration of interruptions;<br>- arrangements/contracts to re-establish utility services;<br>- develop strategies for addressing community-based risks (evacuation plans, staffing/shortage, back-up plans);<br>- an assessment of at-risk population's needs including maintaining independence, communication, transportation, supervision, and medical care;<br>- must identify which staff would assume specific roles in another's absence through succession planning and delegation of authority;<br>- a qualified person who is authorized, in writing, to act in the absence of the administrator;<br>- a process for cooperation and collaboration with local, tribal, regional, State and Federal EP to maintain integrated response;<br>- develop and implement EP policies/procedures and review/update annually;<br>- develop/implement EP policies and procedures to address evacuation and shelter in place for staff and residents which must include:<br>- alternate sources of energy to maintain temperature, safety and sanitary storage of provisions;<br>- alternate sources of energy to fire detection, extinguishing, alarms systems;<br>- a tracking system used to document locations of residents, staff, and relocation of staff;<br>- develop policies and procedures to address safe | 0 680 | | |

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| ARTHUR'S SENIOR CARE | 3310 EMMERT STREET ROSEVILLE, MN 55126 |

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| 0 680 | Continued From page 10<br><br>evacuation from the facility including:<br>- staff responsibilities;<br>- alternate communication means;<br>- develop policy and procedures for shelter in place for residents, staff and volunteers who remain at the facility;<br>- develop policy and procedures must address use of volunteers including process and role for integration;<br>- develop a written communication plan and review/update annually;<br>- communication plan must include all the following names/contact information:<br>- entities providing services under agreement;<br>- residents' physicians;<br>- volunteers;<br>- communication plan must include contact information for:<br>- other sources of assistance;<br>- communication plan must include:<br>- means to provide information about facility occupancy;<br>- and ability to provide assistance;<br>- authority having jurisdiction;<br>- incident Command Center;<br>- or designee;<br>- communication plan must include a method for sharing information from emergency plan;<br>- must develop and maintain EP training and testing program, review/update annually;<br>- must implement emergency and standby power systems based on their EP; and<br>- if part of a healthcare system consisting of separately certified healthcare facilities and elects to have a unified and integrated EP, they may choose to participate.<br><br>During interview on September 21, 2023, at 3:05 p.m., surveyor and DHS-D went over the EPP for missing components and DHS-D confirmed they | 0 680 | | |

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| 0 680 | Continued From page 11<br><br>did not have all the required content, and some content were lacking a clear plan. DHS-D stated licensee had not been reviewing the EPP annually, and the missing person policy was not included in the EPP and was not reviewed quarterly.<br><br>The licensee's 2.28 Missing Resident policy dated August 1, 2022, indicated the licensee would review this policy and any individual resident plans that pertain to elopement at least quarterly, and all changes would be documented.<br><br>The licensee's 9.01 Emergency Preparedness Plan-Appendix Z Compliance policy dated August 1, 2022, indicated the licensee would include all required components of appendix Z. The plan would be in writing and reviewed annually.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 680 | | |
| 0 790 SS=E | 144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment<br><br>(2) install and maintain portable fire extinguishers in accordance with the State Fire Code;<br><br>(3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and | 0 790 | | |

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| 0 790 | Continued From page 12<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to maintain the portable fire extinguishers. This deficient condition had the potential to affect all staff, residents, and visitors.<br><br>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).<br><br>Findings include:<br><br>On September 19, 2023, between 1:55 p.m. and 3:00 p.m., survey staff toured the facility with the director of housing services (DHS)-D. During the facility tour, survey staff observed the following:<br>1. A portable fire extinguisher was stored in an unlabeled kitchen cabinet that was not readily available.<br>2. Fire extinguishers were stored on the floor in the basement mechanical room and main floor laundry room. Fire extinguishers must be properly mounted to prevent them from being moved or damaged.<br><br>On September 19, 2023, between 3:00 p.m. and 4:25 p.m., a record review and interview were completed with DHS-D and house manager (HM)-E. The monthly inspection logs for the portable fire extinguishers were reviewed by survey staff. Inspections were not completed in | 0 790 | | |

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| 0 790 | Continued From page 13<br><br>July 2023 for the portable fire extinguishers. Monthly inspections are required to ensure that each extinguisher is in its designated place, that it has not been tampered with, and that there is no obvious physical damage or condition that would interfere with its use or operation.<br><br>These deficient conditions were verbally verified by DHS-D and HM-E during interview.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 790 | | |
| 0 800 SS=F | 144G.45 Subd. 2 (a) (4) Fire protection and physical environment<br><br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to maintain 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. This deficient condition had the potential to affect all staff, residents, and visitors.<br><br>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 | 0 800 | | |

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| 0 800 | Continued From page 14<br><br>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).<br><br>Findings include:<br><br>On September 19, 2023, between 1:55 p.m. and 3:00 p.m., survey staff toured the facility with the director of housing services (DHS)-D. During the facility tour, survey staff observed the following:<br><br>1. The evacuation map directs occupants to exit the building from the porch out to the deck. The deck was enclosed by railings. All paths of egress must provide unobstructed exiting.<br>2. The evacuation map directs occupants to exit the building through the garage. Exits are required to lead directly to the exterior of the building and not through a higher hazard room.<br>3. There was a hole in the ceiling in a basement bedroom closet.<br><br>These deficient conditions were verified by DHS-D accompanying on the facility tour.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 800 | | |
| 0 810 SS=E | 144G.45 Subd. 2 (b)-(f) Fire protection and physical environment<br><br>(b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:<br>(1) location and number of resident sleeping rooms;<br>(2) employee actions to be taken in the event of | 0 810 | | |

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| 0 810 | Continued From page 15<br><br>a fire or similar emergency;<br>(3) fire protection procedures necessary for residents; and<br>(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.<br>(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.<br>(d) Fire safety and evacuation plans shall be readily available at all times within the facility.<br>(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.<br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on record review and interview, the licensee failed to complete the required employee evacuation drills. This had the potential to affect all staff, residents, and visitors.<br><br>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 | 0 810 | | |

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| 0 810 | Continued From page 16<br><br>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).<br><br>Findings include:<br><br>On September 19, 2023, between 3:00 p.m. and 4:25 p.m., a record review and interview were completed with the director of housing services (DHS)-D and house manager (HM)-E. The evacuation drill logs were reviewed by survey staff. Evacuation drills were not completed in July or August 2023. The evacuation drill frequency requirement of twice per year per shift with at least one evacuation drill every other month was not met.<br><br>DHS-D and HM-E verbally verified this deficient condition during an interview at approximately 4:25 p.m.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 810 | | |
| 0 820 SS=E | 144G.45 Subd. 2 (g) Fire protection and physical environment<br><br>(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 17<br>commissioner for review and approval prior to correction.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to provide facilities that were not a distinct hazard to life. This had the potential to directly affect all residents and staff.<br><br>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).<br><br>The findings include:<br><br>On September 19, 2023, between 1:55 p.m. and 3:00 p.m., survey staff toured the facility with the director of housing services (DHS)-D. During the facility tour, survey staff observed that a keypad with an electromagnetic door lock was installed at the front door, which was designated as an exit. A deadbolt lock was also installed on this door. DHS-D confirmed that this deadbolt lock would not default to the unlocked position under activation of the fire alarm, fire sprinkler system, or loss of power. Any egress door in a locked facility must default to an unlocked position under activation of the fire alarm, fire sprinkler system, or a loss of power.<br><br>This deficient condition was verified by DHS-D accompanying on the facility tour. | 0 820 | | |

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| 0 820 | Continued From page 18<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 820 | | |
| 0 970 SS=C | 144G.50 Subd. 5 Waivers of liability prohibited<br><br>The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal property of a resident. This had the potential to affect all residents living within the assisted living with dementia care facility.<br><br>This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>On September 21, 2023, at 3:05 p.m., director of housing and services (DHS)-D provided the | 0 970 | | |

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| 0 970 | Continued From page 19<br><br>surveyor an undated blank Assisted Living Resident Contract and indicated the resident contract was the most current and was used by the licensee for all residents. The blank resident contract included the following two sections which included language waiving the facilities liability for health, safety, or personal property of a resident:<br>- Page 13: SECTION 22.0-PERSONAL PROPERTY<br>"Facility is not responsible for any loss or damage to Resident's personal property due to theft, or damage due to fire, water, tornado or other acts of nature and events beyond Facility's control," and "In the event Resident's property is damaged or destroyed by fire, efforts to extinguish a fire, or other causes that may be covered by standard fire and extended coverage insurance, or by other insurance coverage, Resident waives: (a) all claims against Facility and its representatives and agents for any such loss or damage; and (b) all rights of subrogation of any insurance company carrying any insurance covering such loss, damage or destruction."<br>- Page 16: SECTION 26.0-INDEMNIFICATION<br>"As an occupant of the Facility, Resident assumes the risk for Resident's own safety and for the safety of Resident's personal property. Resident will indemnify and hold harmless Facility, its employees and agents from and against any and all claims, actions, damages, and liability and expense in connection with loss of life, personal injury or damage to property, arising from or out of the use by Resident of the Bedroom-Bathroom Suite or any other part of Facility, or caused wholly or in part by an act or omission of Resident."<br><br>On September 21, 2023, at 1:45 p.m., DHS-D stated she could identify the waivers of liability within the contract in a few areas. DHS-D stated | 0 970 | | |

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| 0 970 | Continued From page 20<br><br>she would check their resident handbook for waivers of liability and would have those changed.<br><br>The licensee's 1.02 Application and Deposit for Residency policy dated August 1, 2022, indicated the prospective resident would be given a copy of the Assisted Living Contract and Resident Handbook prior to move in for review before signing any agreement. Additionally, the policy indicated the Assisted Living Contract must be signed to secure a specific bedroom suite.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 970 | | |
| 01470 SS=F | 144G.63 Subd. 2 Content of required orientation<br><br>(a) The orientation must contain the following topics:<br>(1) an overview of this chapter;<br>(2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person;<br>(3) handling of emergencies and use of emergency services;<br>(4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC);<br>(5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;<br>(6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person;<br>(7) handling of residents' complaints, reporting of | 01470 | | |

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| 01470 | Continued From page 21<br>complaints, and where to report complaints, including information on the Office of Health Facility Complaints;<br>(8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and<br>(9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure.<br>(b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics:<br>(1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication;<br>(2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or<br>(3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure employees received orientation to 144G licensing | 01470 | | |

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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 |
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| 01470 | Continued From page 22<br><br>requirements for two of two employees (unlicensed personnel (ULP)-B, clinical nurse supervisor (CNS)-F). This had potential to affect all six (6) residents.<br><br>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).<br><br>The findings include:<br><br>ULP-B<br>ULP-B had a hire date of December 13, 2022, to provide services to residents.<br><br>On September 19, 2023, beginning at 8:05 a.m., surveyor observed ULP-B administer medications and personal cares to different residents.<br><br>ULP-B's RN Training Hours for Home Care Certification dated January 11, 2023, indicated ULP-B was trained on the following:<br>-services we provide;<br>-advocacy; and<br>-a guide to home care services.<br><br>CNS-F<br>CNS-F had a hire date of October 1, 2014, and began providing services under the assisted living license on August 1, 2021.<br><br>CNS-F's Training Hours Report received on September 19, 2023, at 4:40 p.m. via email indicated CNS-F received training on "A Guide to | 01470 | | |

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| 01470 | Continued From page 23<br><br>Home Care Services," which was under 144A regulations.<br><br>ULP-B's and CNS-F's employee records lacked documentation of overview of 144G assisted living statutes, consumer advocacy services, and review of types of assisted living services.<br><br>During interview on September 20, 2023, at 9:10 a.m., director of housing and services (DHS)-D stated their online training platform called the "hub," was created by an intern, but they switched over to their new online platform called "Isolve Learn and Grow," as of January 1, 2023, which contained the incorrect information also.<br><br>During interview on September 20, 2023, at 9:45 a.m., DHS-D stated all of management including herself were trained with incorrect information which was on 144A. DHS-D stated they will get the information corrected and retrain everyone who didn't receive the 144G orientation.<br><br>The licensee's 5.01 Orientation of Staff and Supervisors & Content policy dated August 1, 2022, indicated all staff providing and supervising direct services must complete an orientation to Assisted Living facility licensing requirements and regulations before providing services to residents.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01470 | | |
| 01540 SS=F | 144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED<br><br>(3) for assisted living facilities with dementia care, | 01540 | | |

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| 01540 | Continued From page 24<br><br>direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter;<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure employees had completed at least eight (8) hours of initial dementia training within 80 working hours of the employment start date for two of two employees (unlicensed personnel (ULP)-B, clinical nurse supervisor (CNS)-F).<br><br>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).<br><br>The findings include: | 01540 | | |

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| 01540 | Continued From page 25<br><br>ULP-B<br>ULP-B had a hire date of December 13, 2022, to provide direct care to residents.<br><br>On September 19, 2023, beginning at 8:05 a.m., surveyor observed ULP-B administer medications and personal cares to different residents with dementia.<br><br>ULP-B's training record dated December 26, 2022, indicated ULP-B received 1.5 hours for dementia training part 1, and 1.5 hours for dementia training part 2.<br><br>CNS-F<br>CNS-F had a hire date of October 1, 2014, and began providing services under the assisted living license on August 1, 2021.<br><br>CNS-F's Training Hours Report received on September 19, 2023, at 4:40 p.m. via email indicated CNS-F did not receive any dementia training.<br><br>During interview on September 19, 2023, at 3:45 p.m., director of housing and services (DHS)-D indicated when the licensee switched over to the assisted living license, the licensee failed to switch over the correct dementia videos resulting all staff completing 4.2 hours out of required 8 hours. DHS-D stated it was a "technological error" on their end.<br><br>During interview on September 20, 2023, at 9:10 a.m., DHS-D stated the remaining dementia videos that were four hours long didn't get uploaded because the files were too large.<br><br>During interview on September 20, 2023, at 9:37 a.m., director of development (DD)-C stated the | 01540 | | |

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| 01540 | Continued From page 26<br>"dementia video must have gotten clipped," when the online training platform switched over to the new platform.<br><br>CNS-F was unavailable for interview to confirm if he/she received any dementia training.<br><br>The licensee's 3.01 ALDC Additional Dementia Staff Training policy dated August 1, 2022, indicated all direct care staff would have dementia training, but lacked identification of the required hours or timeframe the training would be completed.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01540 | | |
| 01640 SS=D | 144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to<br><br>(a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan.<br>(b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities.<br>(c) The facility must implement and provide all services required by the current service plan.<br>(d) The service plan and the revised service plan | 01640 | | |

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| 01640 | Continued From page 27<br><br>must be entered into the resident record, including notice of a change in a resident's fees when applicable.<br>(e) Staff providing services must be informed of the current written service plan.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure the service plan included a signature or other authentication by the resident and the facility to document agreement on the services to be provided for one of one resident (R2).<br><br>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).<br><br>The findings include:<br><br>R2<br>R2's diagnoses included history of stroke, resulting with right sided paralysis, aphasia (impaired expression and understanding of language), dysarthria (impaired muscles of speech mechanism), legally blind, and hearing loss to both ears.<br><br>R2's Exhibit D Service Plan signed April 3, 2023, listed all available 22 services including frequency, discipline, frequency of supervision by RN and payer for each service by indicating a "check mark" next to each service. | 01640 | | |

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| 01640 | Continued From page 28<br><br>R2's care plan signed on April 3, 2023, indicated R2 received assistance with transfers, toileting, meals, medication administration, dressing and grooming, bathing, and mobility. The following changes were made to the care plan:<br>-"Staff will utilize her pressure alarm whenever she is alone in her bedroom," was crossed out;<br>-Mechanical soft diet (made easier to chew by blending, grounding, or finely chopping) was handwritten in blue ink in place of pureed diet (blended, smooth and moist);<br>-"EZ stand (PRN)" was crossed off; and<br>-Dentures were added under equipment used.<br>In the next column over, under "Person Centered Approach," the care plan indicated R2 used a mechanical lift for transfers PRN (as needed). R2 could also use an EZ stand for transfers. At the bottom of the care plan, it indicated the following:<br>-Date reviewed on April 17, 2023, with transfers changed, dentures added and did not require service plan to be re-signed;<br>-Date reviewed on July 20, 2023, under changes made, "N/A" (not applicable) was indicated in blue ink.<br>The care plan did not specify who made the changes to the care plan nor did it provide a space for the resident or resident's designated representative to sign approving the changes.<br><br>During exit interview on September 22, 2023, at 11:00 a.m., director of housing and services (DHS)-D stated they did not document that they verbally contacted the family to inform them of service plan changes.<br><br>Clinical nurse supervisor (CNS)-F was not available to interview.<br><br>The licensee's 6.10 Service Plan Modifications | 01640 | | |

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| 01640 | Continued From page 29<br><br>policy dated August 1, 2022, indicated when a resident receives assisted living services and a change (s) to the service plan occurs, the service plan must be amended in writing and signed by the resident or the resident's designated representative.<br><br>No further information provided.<br><br>TIME PERIOD TO CORRECT- Twenty-one (21) days | 01640 | | |
| 01650 SS=F | 144G.70 Subd. 4 (f) Service plan, implementation and revisions to<br><br>(f) The service plan must include:<br>(1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences;<br>(2) the identification of staff or categories of staff who will provide the services;<br>(3) the schedule and methods of monitoring assessments of the resident;<br>(4) the schedule and methods of monitoring staff providing services; and<br>(5) a contingency plan that includes:<br>(i) the action to be taken if the scheduled service cannot be provided;<br>(ii) information and a method to contact the facility;<br>(iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and<br>(iv) the circumstances in which emergency | 01650 | | |

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| 01650 | Continued From page 30<br><br>medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure the resident service plan included the required content for two of three residents (R2, R6).<br><br>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).<br><br>The findings include:<br><br>R2<br>R2's diagnoses included history of stroke, resulting with right sided paralysis, aphasia (impaired expression and understanding of language), dysarthria (impaired muscles of speech mechanism), legally blind, and hearing loss to both ears.<br><br>R2's Exhibit D Service Plan signed April 3, 2023, listed all available 22 services the licensee could provide including frequency, discipline, frequency of supervision by RN and payer for each service by indicating a "check mark" next to each service.<br><br>R2's care plan signed on April 3, 2023, indicated R2 received assistance with transfers, toileting, meals, medication administration, dressing and | 01650 | | |

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| 01650 | Continued From page 31<br>grooming, bathing, and mobility.<br><br>During observation and interview on September 19, 2023, starting at 9:48 a.m. through approximately 10:45 a.m., surveyor observed ULP-B administer medication via gastrostomy tube (opening in stomach) to R2, transfer R2 with mechanical lift (full body lift using a sling), and give R2 a shower.<br><br>R6<br>R6's diagnoses included Parkinson's disease, mild cognitive impairment, dementia without behavioral disturbances, peripheral vascular disease (narrowed blood vessels), venous insufficiency (veins had difficulty sending blood back to heart), and vascular statis ulcer (sores caused by lack of blood flow).<br><br>R6's Exhibit D Service Plan signed June 13, 2022, listed all available 22 services the licensee could provide including frequency, discipline, frequency of supervision by RN and payer for each service by indicating a "check mark" next to each service.<br><br>R6's care plan signed on June 8, 2023, indicated R6 received assistance with wound care, medication administration, bathing, toileting, dressing and grooming, and meals.<br><br>On September 19, 2023, at 8:14 a.m., surveyor observed unlicensed personnel (ULP)-B set up and administer medications to R6. ULP-G prepared breakfast and cut up R6's food.<br><br>R2 and R6's service agreements lacked personalization of the following content on their service plans:<br>-a description of the services to be provided; | 01650 | | |

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| 01650 | Continued From page 32<br><br>-the identification of staff or categories of staff who will provide the services;<br>-the schedule and methods of monitoring assessments of the resident; and<br>-the schedule and methods of monitoring staff providing services.<br><br>During interview on September 19, 2023, at 1:03 p.m., director of housing and services (DHS)-D, stated the Service Agreement was a blanket form the licensee used for all residents. DHS-D stated the form was not personalized to each resident, but it was to explain what services could be provided in their all-inclusive fee. DHS-D stated since the service agreements were not personalized, they would make that change to meet the requirements.<br><br>Clinical nurse supervisor (CNS)-F was not available for interview.<br><br>The licensee's 6.08 Service Plan policy dated August 1, 2022, indicated the service plan must include:<br>-description of services that are to be provided based on the most recent assessment and resident preferences;<br>-fees for services to be provided;<br>-the frequency of each service to be provided based on the most recent assessment and resident preferences;<br>-an identification of the type staff or categories that will provide the services (RN/LPN, Unlicensed Personnel, etc.)<br>-a schedule and method for the next planned assessment or monitoring;<br>-a schedule and method for the next planned monitoring of staff providing services;<br>-a contingency plan that includes:<br>a. actions {licensee} will take if scheduled | 01650 | | |

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| 01650 | Continued From page 33<br><br>service cannot be provided;<br>b. information regarding how the resident can contact {licensee};<br>c. identification and contact information of who the resident has authorized, if any, to sign for the resident in an emergency; and<br>d. how the facility will support documented resident health care directive decisions, if any-including circumstances in which emergency medical services are not to be summoned.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION:<br>Twenty-One (21) days | 01650 | | |
| 01790 SS=F | 144G.71 Subd. 10 Medication management for residents who will<br><br>(2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days;<br>(3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and<br>(4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled.<br>(b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if:<br>(1) the registered nurse has trained the unlicensed staff and determined the unlicensed | 01790 | | |

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| 01790 | Continued From page 34<br><br>staff is competent to follow the procedures for giving medications to residents; and<br>(2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address:<br>(i) the type of container or containers to be used for the medications appropriate to the provider's medication system;<br>(ii) how the container or containers must be labeled;<br>(iii) written information about the medications to be provided;<br>(iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information;<br>(v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative;<br>(vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and<br>(vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication.<br><br>This MN Requirement is not met as evidenced by: | 01790 | | |

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| ARTHUR'S SENIOR CARE | 3310 EMMERT STREET ROSEVILLE, MN 55126 |

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| 01790 | Continued From page 35<br><br>Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) developed training and competencies for unlicensed personnel (ULP) providing medications to residents for unplanned time away from home when the licensed nurse was not available for one of one ULP (ULP-B).<br><br>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).<br><br>The findings include:<br><br>ULP-B had a hire date of December 13, 2022, to provide direct cares to residents.<br><br>On September 19, 2023, beginning at 8:05 a.m., surveyor observed ULP-B administer medications and personal cares to multiple residents.<br><br>ULP-B's record lacked documentation of training and competencies for unplanned time away when the RN was not available.<br><br>On September 20, 2023, at 12:41 p.m., house manager (HM)-E stated ULP-B's training packet showed that ULP-B received training on unplanned times away. HM-E was unable to show that ULP-B received training and deemed competent by an RN for this task.<br><br>On September 20, 2023, at 1:06 a.m., director of development (DD)-C indicated the licensee used the medication administration self-study and | 01790 | | |

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| 01790 | Continued From page 36<br><br>homework training packet, page 21, as their training and competency for unplanned times away. The house manager would then go over the packet with the ULP once completed. They did not have documentation of training and competency completed by the RN. This practice was used for all ULPs.<br><br>Clinical nurse supervisor (CNS)-F was not available for interview.<br><br>The licensee's 7.10 Medication Management-Planned & Unplanned Time Away policy dated August 1, 2022, indicated for unplanned resident time away when the licensed nurse was unavailable, the RN may delegate this task to the ULP if the RN had trained ULPs and determined the unlicensed staff were competent to follow the procedures for giving medications to residents.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01790 | | |
| 01940 SS=F | 144G.72 Subd. 3 Individualized treatment or therapy managemen<br><br>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: | 01940 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| 01940 | Continued From page 37<br><br>(1) a statement of the type of services that will be provided;<br>(2) documentation of specific resident instructions relating to the treatments or therapy administration;<br>(3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel;<br>(4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and<br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for three of three residents (R2, R6, R4).<br><br>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).<br><br>The findings include: | 01940 | | |

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| 01940 | Continued From page 38<br><br>During the entrance conference on September 18, 2023, at approximately 10:25 a.m., director of housing and services (DHS)-D stated the licensee provided treatment management services to residents, including wound care and modified diets (altering the texture of foods).<br><br>WOUND CARE<br>R2<br>R2's diagnoses included history of stroke, resulting with right sided paralysis, aphasia (impaired expression and understanding of language), dysarthria (impaired muscles of speech mechanism), legally blind, and hearing loss to both ears.<br><br>R2's Exhibit D Service Plan signed April 3, 2023, listed all available 22 services including frequency, discipline, frequency of supervision by RN and payer for each service by indicating a "check mark" next to each service.<br><br>R2's care plan signed on April 3, 2023, indicated R2 received assistance with transfers, monitor skin integrity, toileting, meals, medication administration, dressing and grooming, bathing, and mobility.<br><br>R2's medical provider orders signed April 3, 2023, ordered Mepilex (foam dressing) to coccyx (tailbone): change every Monday, Wednesday, Friday, and PRN (as needed) if soiled. Cleanse area with wound cleanser or mild soap and water. Apply skin prep before placing new Mepilex.<br><br>R2's health progress note dated September 5, 2023, at 12:11 p.m., ULP-K indicated R2 now had two open red wounds on right buttock, which was covered with Mepilex bandage. | 01940 | | |

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| 01940 | Continued From page 39<br><br>R2's Medication Administration Record (MAR) dated September 2023, indicated documentation for "mediplex [sic] to coccyx-change every Mon, Wed, Fri and as needed if soiled."<br><br>On September 19, 2023, at 2:16 p.m., surveyor asked ULP-B if R2 currently had a wound to her buttock, ULP-B stated no. ULP-B then stated they put the Mepilex on Monday, Wednesdays, Fridays, and PRN per family request for peace of mind.<br><br>R6<br>R6's diagnoses included Parkinson's disease, mild cognitive impairment, dementia without behavioral disturbances, peripheral vascular disease (narrowed blood vessels), venous insufficiency (veins had difficulty sending blood back to heart), and vascular statis ulcer (sores caused by lack of blood flow).<br><br>R6's Exhibit D Service Plan signed June 13, 2022, listed all available 22 services the licensee could provide including frequency, discipline, frequency of supervision by RN and payer for each service by indicating a "check mark" next to each service.<br><br>R6's care plan signed on June 8, 2023, indicated R6 received assistance with wound care, medication administration, bathing, toileting, dressing and grooming, and meals.<br><br>On September 19, 2023, at 8:14 a.m., surveyor observed ULP-B set up and administer medications to R6. ULP-G prepared breakfast and cut up R6's food. Surveyor also observed an ACE bandage wrap to left ankle. | 01940 | | |

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| 01940 | Continued From page 40<br><br>R6's Physician's Order signed March 27, 2023, ordered the following:<br>-Ace wrap to left lower leg-on in morning (AM), off in evening (PM);<br>-left ankle wound care: cleanse left inner ankle with normal saline, cover with non-adhesive Telfa (nonstick dressing pad), and wrap with layer of Kerlix (gauze bandage roll used for cushion and protection) every day. Okay to use Medihoney (medical grade honey used in wound care);<br>-Left calf wound care: cleanse left inner calf with normal saline, apply Vaseline gauze cut to size of open area, cover with non-adhesive Telfa and wrap with layer of kerlix every day. Okay to use Medihoney; and<br>-change wound care dressing as needed for saturation.<br><br>R6's MAR dated September 2023, indicated documentation for above listed wound care performed daily by ULPs.<br><br>During interview on September 21,2023, at 12:24 p.m., ULP-I stated family provided a "cheat sheet" on how to perform R6's wound care.<br><br>R2 and R6's record lacked a treatment management plan to include the following required content:<br>- identification of the person responsible for monitoring any treatment supplies are ordered on a timely basis;<br>-identification of the staff who are responsible for the treatment management tasks, including tasks delegated to unlicensed staff; and<br>- 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 | 01940 | | |

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| 01940 | Continued From page 41<br>complications or adverse reactions.<br><br>MODIFIED DIET<br>R2's Modified Regular Diet Orders signed May 2, 2023, ordered R2 to receive soft/mechanical soft diet: moist, semi-solid foods made easier to chew/swallow via use of a food processor. Foods may be softened by cooking or mashing; canned or soft-cooked fruits and vegetables may be used.<br><br>R2's care plan signed on April 3, 2023, but last reviewed by an unknown person on July 20, 2023, indicated R2 went from pureed diet to mechanical soft diet. It also indicated "staff will assist with feeding by scooping food onto her spoon and handing it to her." It did not specify which staff would be responsible.<br><br>R2's medical record included documentation of the following for each meal: meal type (breakfast, lunch, dinner or snack), meal offered (type of foods), percentage eaten, and if supplement (Ensure) was offered.<br><br>On September 19, 2023, at 11:33 a.m., surveyor observed ULP-G provide feeding assistance to R2 (thick blended pancakes).<br><br>R4<br>R4's diagnoses included Parkinson's disease, dementia related to Parkinson's disease, and history of falls.<br><br>R4's care plan signed on July 19, 2022, indicated R4 received assistance with mobility, transfers using a mechanical lift, toileting, dressing and bathing. The care plan indicated R4 was on a regular diet but may need assistance cutting up foods. | 01940 | | |

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| 01940 | Continued From page 42<br><br>R4's Modified Regular Diet Orders signed July 23, 2020, indicated R4 required regular food and thin liquids. On the same document, there was an undated and unsigned yellow post it note indicating the following, "Please puree [blended or ground food to a soft and smooth consistency] all food. Nectar thick liquids [easily pourable or heavy syrup consistency]."<br><br>R4's Medical Referral Form signed by a medical provider on March 14, 2023, indicated R4 had a history of choking, family okay with ad lib (as desired). The document also indicated it was okay to eat full diet ad lib.<br><br>On September 20, 2023, at 12:30 p.m., surveyor observed ULP-B sitting next to R4 while in a Broda chair (tilting chair with cushions), provide feeding assistance to R4. R4's lunch consisted of thickened liquid, mashed bananas, and blended pizza in the consistency of mashed potatoes.<br><br>R2 and R4's record lacked a treatment management plan to include the following required content:<br>- identification of the type of services that will be provided;<br>- identification of any specific resident instructions regarding treatments or therapy administration;<br>- documentation of specific resident instructions relating to the treatments or therapy administration;<br>- procedures for notifying a registered nurse when a problem arose with treatments or therapy services;<br>-identification of the staff who are responsible for the treatment management tasks, including tasks delegated to unlicensed staff; and<br>- any resident-specific requirements relating to | 01940 | | |

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| 01940 | Continued From page 43<br><br>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.<br><br>During interview on September 20, 2023, at 4:09 p.m., HM-E stated there were no written procedures for when ULPs would need to modify R4's meal. HM-E stated the ULPs decided as they created meals. The only document available for them to reference was R4's care plan (which indicated R4 was on a regular diet but may need assistance cutting up foods).<br><br>Clinical nurse supervisor (CNS)-F was not available for interview.<br><br>The licensee's 7.05 Treatment & Therapy Management Plan policy dated August 1, 2022, indicated the licensee would develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following:<br>- statement of the type of services that will be provided;<br>- documentation of any specific resident instructions regarding treatments or therapy administration;<br>-identification of the treatment tasks that will be delegated to unlicensed personnel;<br>- procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatment or therapy received;<br>- any resident-specific requirements relating to documentation of treatment and therapy completion, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent | 01940 | | |

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| 01940 | Continued From page 44<br><br>possible complications or adverse reactions. Additionally, the policy indicated the treatment or therapy management record must be current and updated when there were any changes.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01940 | | |
| 01950 SS=F | 144G.72 Subd. 4 Administration of treatments and therapy<br><br>Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has:<br>(1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures;<br>(2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to ensure a registered nurse (RN) trained and verified competency on treatments and therapies for unlicensed | 01950 | | |

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| 01950 | Continued From page 45<br><br>personnel (ULP) for two of two employees (ULP-B, ULP-G).<br><br>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).<br><br>The findings include:<br><br>ULP-B had a hire date of December 13, 2022, to provide direct care to residents.<br><br>ULP-G had a hire date of July 12, 2023, to provide direct care to residents.<br><br>During observation and interview on September 19, 2023, at 8:05 a.m., ULP-G blended pancake in the food processor. The consistency was thick and gummy. ULP-G stated he/she was trained by the RN on how to modify foods.<br><br>On September 20, 2023, at 12:30 p.m., surveyor observed unlicensed personnel (ULP)-B sitting next to R4 while in a Broda chair (tilting chair with cushions), provide feeding assistance to R4. R4's lunch consisted of thickened liquid, mashed bananas, and blended pizza in the consistency of mashed potatoes.<br><br>ULP-B and ULP-G's training record lacked evidence of training and demonstrated competency to an RN to perform wound care and modified diets (altering the texture of foods). | 01950 | | |

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| 01950 | Continued From page 46<br><br>During interview on September 20, 2023, at 10:40 a.m., ULP-B stated for modified diets, he/she was trained through a mixture of training, such as videos and at staff meetings.<br><br>During interview on September 20, 2023, at 1:19 p.m., director of development (DD)-C provided a competency check list for ULP-B containing wound care, but it was signed off by house manager (HM)-E. DD-C stated HM-E, who was not a nurse, was delegated to train and check off staff on wound care.<br><br>During interview on September 21, 2023, at 11:14 a.m., ULP-G stated he/she watched a video on wound care but was not checked off by an RN. ULP-G stated HM-E and other ULPs trained ULP-G during shadowing.<br><br>During interview on September 21, 2023, at 12:24 p.m., ULP-I could not remember if he/she watched a video on wound care but knew he/she was not checked off by an RN. ULP-I stated wound care training was provided by other staff. For modified diets, ULP-I was trained by staff during shadowing but was not tested out by an RN. ULP-I stated during staff meetings with the RN, they would do random quizzes, but he/she was not taught by the nurse.<br><br>Clinical nurse supervisor (CNS)-F was not available for interview.<br><br>The licensee's 6.14 Delegation of Assisted Living Services policy dated August 1, 2022, indicated when the RN delegates tasks to ULP, that person will ensure that prior to the delegation the ULP is trained in the proper methods to perform the tasks or procedures for each resident and is able to demonstrate the ability to competently follow | 01950 | | |

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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 |
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| 01950 | Continued From page 47<br><br>the procedures and perform the tasks. The policy also indicated the RN will document instructions for the delegated tasks in the resident's record.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01950 | | |
| 02040 SS=F | 144G.81 Subdivision 1 Fire protection and physical environment<br><br>An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements:<br>(1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and<br>(2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029.<br><br>This MN Requirement is not met as evidenced by:<br>Based on record review and interview, the licensee failed to provide a safety risk assessment or hazard vulnerability assessment of the physical environment on and around the property with mitigation factors for the facility. This deficient practice had the ability to affect all staff, residents, and visitors.<br><br>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 | 02040 | | |

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| | 27856 | A. BUILDING: _____ B. WING _____ | 09/22/2023 |

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| 02040 | Continued From page 48<br><br>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).<br><br>Findings include:<br><br>On September 19, 2023, between 3:00 p.m. and 4:25 p.m., a record review and interview were completed with the director of housing services (DHS)-D and house manager (HM)-E.<br><br>Record review of the available documentation indicated that the licensee had included a hazard and vulnerability assessment tool that identified natural, technological, and human hazards. An assessment of the physical environment that identified safety risks or hazards on and around the property with mitigation factors had not been completed.<br><br>DHS-D and HM-E verbally verified this deficient condition during an interview at approximately 4:25 p.m.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 02040 | | |
| 02170 SS=D | 144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA<br><br>(b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following:<br>(1) past and current interests;<br>(2) current abilities and skills;<br>(3) emotional and social needs and patterns;<br>(4) physical abilities and limitations; | 02170 | | |

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| 02170 | Continued From page 49<br><br>(5) adaptations necessary for the resident to participate; and<br>(6) identification of activities for behavioral interventions.<br>(c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs.<br>(d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to:<br>(1) occupation or chore related tasks;<br>(2) scheduled and planned events such as entertainment or outings;<br>(3) spontaneous activities for enjoyment or those that may help defuse a behavior;<br>(4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music;<br>(5) spiritual, creative, and intellectual activities;<br>(6) sensory stimulation activities;<br>(7) physical activities that enhance or maintain a resident's ability to ambulate or move; and<br>(8) outdoor activities.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure an individualized activity plan contained all required content for one of one resident (R2).<br><br>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 | 02170 | | |

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| 02170 | Continued From page 50<br><br>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).<br><br>The findings include:<br><br>R2's diagnoses included history of stroke, resulting with right sided paralysis, aphasia (impaired expression and understanding of language), dysarthria (impaired muscles of speech mechanism), legally blind, and hearing loss to both ears.<br><br>R2's Exhibit D Service Plan signed April 3, 2023, listed all available 22 services including frequency, discipline, frequency of supervision by RN and payer for each service by indicating a "check mark" next to each service.<br><br>R2's care plan signed on April 3, 2023, indicated R2 received assistance with transfers, monitor skin integrity, toileting, meals, medication administration, dressing and grooming, bathing, and mobility.<br><br>R2's medical record lacked an assessment of the residents' past interests, current abilities and skills, emotional and social needs and patterns, physical limitations, and identifications of activities for behavioral interventions.<br><br>On September 19, 2023, at 1:50 p.m., director of housing and services (DHS)-D showed surveyor an email received from R2's family with some personal preferences and history, but it did not contain all the required content.<br><br>On September 22, 2023, at 11:00 a.m., DHS-D stated family did not write out a "getting to know | 02170 | | |

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| 02170 | Continued From page 51<br><br>you" form. The other residents' forms were put into the daily book binder. The monthly calendar was a base, but in the licensee's online platform called SharePoint, it was where they had activity plans created by the house manager. DHS-D also stated they performed person-centered cares.<br><br>The licensee's 3.05 ALDC Life Enrichment Programs, Activities & Outdoor Space policy dated August 1, 2022, indicated each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following:<br>-past and current interests;<br>-current abilities and skills;<br>-emotional and social needs and patterns;<br>-physical abilities and limitations;<br>-adaptations necessary for the resident to participate; and<br>-identification of activities for behavioral interventions.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 02170 | | |
| 02310 SS=F | 144G.91 Subd. 4 (a) Appropriate care and services<br><br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record | 02310 | | |

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| 02310 | Continued From page 52<br><br>review, the licensee failed to ensure the care and services were appropriate based on the needs of residents who resided in the secured facility with regards to safely storing chemicals. This had the potential to affect all six (6) residents, staff, and visitors of the secured facility.<br><br>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).<br><br>The findings include:<br><br>The licensee held an assisted living with dementia care license.<br><br>On September 19, 2023, at 8:33 a.m., surveyor observed cleaning chemicals in an unlocked cabinet above the toilet and in an unlocked cabinet below the sink of the same bathroom which was located near the common area at the start of the hallway leading to the bedrooms. This bathroom was a public bathroom which always remained unlocked. The bathroom contained the following chemicals: Lysol toilet bowl cleaner, Shout laundry stain remover, Pledge cleaner, Scrubbing Bubbles shower foamer, Jaws Disinfectant cleaner, and Jaws Glass cleaner.<br><br>On September 19, 2023, at 1:35 p.m., surveyor observed Lysol toilet bowl cleaner unsecured in R5's bathroom cabinet above the toilet and Clorox Wipes and Lysol toilet bowl cleaner unsecured in R6's bathroom cabinet above the | 02310 | | |

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| 02310 | Continued From page 53<br>toilet.<br><br>The Shout Triple Acting Laundry Stain Remover Safety Data Sheet dated March 4, 2015, indicated to avoid contact with skin, eyes and clothing and wash thoroughly after handling.<br><br>The Pledge Multi Surface Everyday Cleaner Safety Data Sheet dated December 18, 2017, indicated to avoid contact with skin, eyes, and clothing.<br><br>The Scrubbing Bubbles Mega Shower Foamer Safety Data Sheet dated June 4, 2018, indicated to avoid contact with skin, eyes, and clothing. It also indicated it may cause respiratory tract irritation.<br><br>The Lysol Disinfectant Toilet Bowl Cleaner Safety Data Sheet dated April 6, 2020, indicated the disinfectant solution was harmful if swallowed and could cause severe skin burns and eye damage.<br><br>The Jaws Glass Cleaner Concentrate Safety Data Sheet revised on February 9, 2021, indicated it caused skin irritation, serious eye irritation and may cause an allergic skin reaction.<br><br>The Jaws Disinfectant Cleaner Concentrate Safety Data Sheet revised on February 15, 2021, indicated it could cause severe skin burns and eye damage.<br><br>On September 19, 2023, at 2:16 p.m., unlicensed personnel (ULP)-B stated he/she was trained not to store cleaning supplies above in the kitchen as they could leak down, but the toilet bowl cleaner was either stored next to the toilet or in the cabinet of the resident's bathroom. | 02310 | | |

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| 02310 | Continued From page 54<br><br>On September 21, 2023, at 11:14 a.m., director of housing and services (DHS)-D indicated the Minnesota Department of Health's environmental engineer had discussed the chemicals not being secured. DHS-D stated she planned to have them locked up as they didn't have their mitigation completed.<br><br>On September 21, 2023, at 1:45 p.m., surveyor requested the safety data sheets for each chemical they used. DHS-D stated they did not have them, but referenced the label on each bottle for information, or would call poison control.<br><br>The licensee's 3.09 ALDC Physical Environment, Fire Protection & Staffing policy dated August 1, 2022, indicated a hazard vulnerability assessment would be on file. Identified hazards are assessed with reasonable mitigation strategies employed to protect residents from harm.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 02310 | | |
| 02320 SS=G | 144G.91 Subd. 4 (b) Appropriate care and services<br><br>(b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan.<br><br>This MN Requirement is not met as evidenced by: | 02320 | | |

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| 02320 | Continued From page 55<br><br>Based on observation, interview, and record review, the licensee failed to provide unlicensed personnel (ULP) with specific procedures on how and when modify a meal for one of one resident (R4) due to history of choking.<br><br>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, or a violation that has the potential to lead to 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).<br><br>The findings include:<br><br>On September 20, 2023, at 12:30 p.m., surveyor observed unlicensed personnel (ULP)-B sitting next to R4 while in a Broda chair (tilting chair with cushions), providing feeding assistance to R4. R4's lunch consisted of thickened liquid, mashed bananas and blended pizza in the consistency of mashed potatoes.<br><br>R4 was admitted to licensee for services on July 28, 2020, with diagnoses to include Parkinson's disease, dementia related to Parkinson's disease, and history of falls.<br><br>R4's care plan signed on July 19, 2022, indicated R4 received assistance with mobility, transfers using a mechanical lift, toileting, dressing and bathing. The care plan indicated R4 was on a regular diet but may need assistance cutting up foods.<br><br>R4's Uniform Assessment Tool completed by a registered nurse (RN) dated July 20, 2023, | 02320 | | |

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| 02320 | Continued From page 56<br><br>indicated under Personal Lifestyle Preferences; dietary needs required no special instructions; see modified diet order/care plan for full details.<br><br>R4's Modified Regular Diet Orders signed July 23, 2020, indicated R4 required regular food and thin liquids. On the same document, there was an undated and unsigned yellow post it note indicating the following, "Please puree [blended or ground food to a soft and smooth consistency] all food. Nectar thick liquids [easily pourable or heavy syrup consistency]."<br><br>R4's Medical Referral Form signed by a medical provider on March 14, 2023, indicated R4 had a history of choking, family okay with ad lib (as desired). The document also indicated it was okay to eat full diet ad lib.<br><br>R4's Health Progress Notes (HPN) dated August 20, 2023, indicated at 1:40 p.m., staff were feeding R4 when she began to choke. R4's face turned bright red and was becoming purple. For about 30 seconds, R4 was choking and not able to take a breath in. Staff sat her forward and pat her back a few times. R4 eventually coughed and then swallowed and returned to baseline respirations. On call RN was alerted, on call housing manager (HM) was present and notified family. No further instruction was given by RN.<br><br>R4's HPN dated September 3, 2023, at 11:00 a.m., indicated at 10:00 a.m., staff were feeding R4 when she began to choke. Her face turned bright red, and her lips became purple for about 30 seconds R4 was choking and not able to take a breath in. Staff sat her forward and pat her back a few times. R4 eventually coughed and then swallowed her mucus and returned to baseline respirations after five minutes. On call RN and | 02320 | | |

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| 02320 | Continued From page 57<br>HM notified. No further instruction from RN.<br><br>R4's HPN dated September 12, 2023, at 7:00 p.m., indicated when R4 was eating dinner at about 5:30 p.m., she stopped breathing and her lips turned blue. Staff leaned her forward and patted her on the back until she started to cough and breathe again. This lasted for about 10 minutes and when staff put her to bed, she was still slightly coughing. Staff kept her laying up in bed and will continue to monitor. RN and HM notified.<br><br>During interview on September 20, 2023, at 12:41 p.m., HM-E stated most ULPs are giving R4 nectar thick liquids and mechanical soft (made easier to chew by blending, grounding, or finely chopping) or pureed meals.<br><br>During interview on September 20, 2023, at 3:39 p.m., ULP-H stated they were taught on how and when to modify R4's meals during staff meetings with the house manager and house director. ULP-H preferred to use pureed and nectar/honey thickened liquids because of R4's choking history.<br><br>During interview on September 20, 2023, at 4:09 p.m., HM-E stated there were no written procedures for when ULPs would need to modify R4's meal. HM-E stated the ULPs decide as they go. The only document available for them to reference is R4's care plan (which indicated R4 was on a regular diet but may need assistance cutting up foods).<br><br>The licensee's 6.14 Delegation of Assisted Living Services policy dated August 1, 2021, indicated when the RN delegates tasks to ULP, that person will ensure that prior to the delegation the ULP is trained in the proper methods to perform the | 02320 | | |

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| 02320 | Continued From page 58<br><br>tasks or procedures for each resident and is able to demonstrate the ability to competently follow the procedures and perform the tasks. The policy also indicated the RN will document instructions for the delegated tasks in the resident's record.<br><br>The International Dysphagia Diet Standatisation Initiative (IDDSI)'s Complete IDDSI Framework dated July 2019, described five different textures of liquid (ranging from thin to extremely thick), and five different textures of food (ranging from regular to liquidized). The framework described six different tests that can be performed to determine the appropriate textures of liquid and food based on the individual patient's scores. The framework identified the following textures that pose a choking risk:<br>- Hard or dry;<br>- Fibrous or tough;<br>- Chewy;<br>- Crispy;<br>- Crunchy;<br>- Sharp or spiky;<br>- Crumbly;<br>- Pits, seeds, and white parts of fruit;<br>- Skins, husks, and outer shells;<br>- Bone or gristle;<br>- Round or long shaped foods;<br>- Sticky or gummy;<br>- Stringy;<br>- Mixed thin-thick;<br>- Complex foods;<br>- Floppy;<br>- Juicy; and<br>- Hard skins or crust.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: IMMEDIATE | 02320 | | |

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| 02320 | Continued From page 59<br>The immediacy of the order was removed on September 22, 2023, based on supervisory review. The scope and level remain unchanged. | 02320 | | |

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

Type: Full
Date: *09/19/23*
Time: 12:30:00
Report: 1005231213

# Food and Beverage Establishment Inspection Report



**Location:**
Arthur'S Senior Care
3310 Emmert Street
Roseville, MN55126
Ramsey County, 62

**Establishment Info:**
ID #: 0038847
Risk:
Announced Inspection: No

**License Categories:**

Expires on: / /

**Operator:**

Phone #: 6512944798
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.

**Food and Equipment Temperatures**

Process/Item: Cold Hold/MILK
Temperature: 38 Degrees Fahrenheit - Location: KITCHEN REFRIGERATOR
Violation Issued: No

Process/Item: Cold Hold/RICOTTA
Temperature: 33 Degrees Fahrenheit - Location: KITCHEN REFRIGERATOR
Violation Issued: No

Process/Item: Cold Hold/CUT MELON
Temperature: 40 Degrees Fahrenheit - Location: KITCHEN REFRIGERATOR
Violation Issued: No

Process/Item: Cold Hold/BUTTER
Temperature: 41 Degrees Fahrenheit - Location: PANTRY REFRIGERATOR
Violation Issued: No

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

INSPECTION COMPLETED WITH DIRECTOR AND REVIEWED WITH HRD NURSE EVALUATOR ANNA BOHNEN.

DISCUSSED GLOVE USE, DATE MARKING, COOKING TEMPERATURES, AND EMPLOYEE ILLNESS. AN IRREVERSIBLE REGISTERING TEMPERATURE INDICATOR WAS ON SITE AND A LOG IS KEPT THAT SHOWS THE DISHWASHER IS PROVIDING A UTENSIL SURFACE TEMPERATURE OF 160 DEGREES F OR ABOVE.

KITCHEN IS RESIDENTIAL AND FOOD IS PREPARED FOR SAME DAY SERVICE.

Type: Full
Date: *09/19/23*
Time: 12:30:00
Report: 1005231213
Arthur'S Senior Care

# 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 1005231213 of 09/19/23.

Certified Food Protection Manager: DANIELLE BAUMANN

Certification Number: FM109052 Expires: 07/26/24

**Inspection report reviewed with person in charge and emailed.**

Signed: _____

FELICIA WAGNER
DIRECTOR

Signed: _____

Jessica Davis
Public Health Sanitarian III
651-201-3961
jessica.davis@state.mn.us