DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

February 7, 2025

Licensee
Premier Home Care LLC
7120 13th Avenue South
Richfield, MN 55423

RE: Project Number(s) SL35138015

Dear Licensee:

On December 17, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the September 18, 2024, 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,

Tim Hanna, Supervisor
State Engineering Services Section
Health Regulation Division
Email: Tim.Hanna@state.mn.us
Telephone: 507-208-8982 Fax: 1-866-890-9290

JMD

Electronically Delivered

October 24, 2024

Licensee
Premier Home Care LLC
7120 13th Avenue South
Richfield, MN 55423

RE: Project Number(s) SL35138015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on September 18, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

The correction order documentation should include the following:

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

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

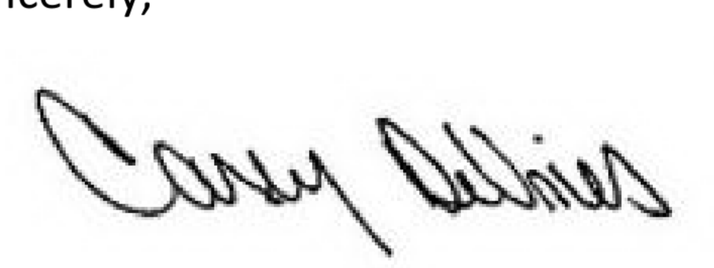
To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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

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

If you have any questions, please contact me.

Sincerely,



Casey DeVries, Supervisor
State Evaluation Team
Email: Casey.DeVries@state.mn.us
Telephone: 651-201-5917 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
	35138	A. BUILDING: _____ B. WING _____	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER HOME CARE LLC	7120 13TH AVENUE SOUTH RICHFIELD, MN 55423

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL35138015-0 On September 16, 2024, through September 18, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction are issued. At the time of the survey there were four residents residing at the facility, all four residents were receiving assisted living services. An immediate correction order was identified on September 17, 2024, issued for SL35138015-0, tag identification 0820. During the survey, the licensee took action to mitigate the immediate risk. However, noncompliance remained, and the scope and level remain unchanged.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470		

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0 470	Continued From page 1 determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure their staffing plan was updated at least two times per year to ensure the staffing needs of residents were met at all times. 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	0 470		

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0 470	Continued From page 2 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On September 16, 2024, at 10:17 a.m., during the entrance conference licensed assisted living director (LALD)-D, they stated they did not have a staffing plan. On September 16, 2024, at 12:20 p.m., during the entrance conference with clinical nurse supervisor (CNS)-A, they stated they did not create a staffing plan and were unaware of the staffing plan requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This had the potential to affect all residents of the assisted living facility.	0 480		

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0 480	Continued From page 3 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated September 16, 2024, for the specific Minnesota Food Code deficiencies. The Inspection Report was provided to the licensee on September 18, 2024. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 500 SS=F	144G.41 Subd. 2 Policies and procedures Each assisted living facility must have policies and procedures in place to address the following and keep them current: (1) requirements in section 626.557, reporting of maltreatment of vulnerable adults; (2) conducting and handling background studies on employees; (3) orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; (4) handling complaints regarding staff or services provided by staff; (5) conducting initial evaluations of residents' needs and the providers' ability to provide those services;	0 500		

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0 500	Continued From page 4 (6) conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; (7) orientation to and implementation of the assisted living bill of rights; (8) infection control practices; (9) reminders for medications, treatments, or exercises, if provided; (10) conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; (11) ensuring that nurses and licensed health professionals have current and valid licenses to practice; (12) medication and treatment management; (13) delegation of tasks by registered nurses or licensed health professionals; (14) supervision of registered nurses and licensed health professionals; and (15) supervision of unlicensed personnel performing delegated tasks. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement current policies and procedures as required. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems	0 500		

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0 500	Continued From page 5 are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On September 17, 2024, at 2:23 p.m., the surveyor sent an email request to licensed assisted living director (LALD)-D for the licensee's staff orientation and training policies. On September 18, 2024, at 6:45 a.m., LALD-D emailed the surveyor the licensee's Staff Orientation and Education policy dated May 26, 2020, which referenced "MN Statute 144A.4795 and 4796," a Minnesota Home Care Statute. The licensee's Assisted Living license required policies and procedures to address Assisted Living Statutes under Chapter 144G. On September 18, 2024, at 9:37 a.m., LALD-D stated they were not aware some of their policies and trainings were out of date and addressed home care statutes. The following of the licensee's medication related policies were dated May 29, 2020, and referenced MN Statute 144A.4792: -Assessment for Medication Management Program; -Service Plan for Medication Management; -Medication Administration; -Medication Documentation; -Supervision of Medication Administration; -Storage/Control of Medications; -Prescriber Orders; -Coordination in the Medication Management Program; -Client Education; -Medication Management Plan for Clients Away	0 500		

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0 500	Continued From page 6 from Home; -Disposition/Disposal of Medications; -Medication Supply; and -Medication Incidents/Errors. In addition, the licensee's Staff Orientation and Education policy dated May 26, 2020, referenced MN Statute 144A.4795 and 4796, and indicated the following: "3. Orientation topics will include, but not be limited to, the following a. Overview of Minnesota Home Care Statute Sections 144A.43 to 144A.4798 b. Review of the employee's job description and responsibilities c. Review of the organization's policies and procedures related to the provision of home care services by the staff member d. Handling of emergencies and the use of emergency services e. Compliance with Minnesota's Vulnerable Adult/Minor Acts (Sections 626.556 and 626.557) and specific requirements per organizational policy, including information on common entry point f. Home Care Bill if Rights g. Grievance Policy/Process h. Consumer advocacy services, including i. Office of Ombudsman for Long-Term-Care ii. Office of Ombudsman for Mental Health iii. Office of Ombudsman for Developmental Disabilities iv. Managed Care Ombudsman at the Department of Human Services v. County managed care advocates vi. Other advocacy services i. Organization's Scope of Services 7. Staff providing home care will also be oriented to the individual client's services. This orientation	0 500		

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0 500	Continued From page 7 may be provided in person, in writing or electronically. 10. All staff providing direct home care will complete at least eight (8) hours of education for every twelve (12) months of employment. 11. Education topics will include, but not be limited to, the following a. Reporting of maltreatment of adults or minors b. Review of Home Care Bill if Rights c. Review of the organization's policies and procedures related to implementation of home care services d. Infection control techniques used in the home i. Implementation of infection control standards based on current recommendations per the CDC**** ii. Hand washing iii. Need for/use of personal protective equipment (PPE) iv. Appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes and razor blades v. Disinfection of reusable equipment vi. Disinfection of environmental surfaces vii. Reporting of communicable diseases." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 500		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies	0 680		

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0 680	Continued From page 8 temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop a written emergency preparedness plan (EPP) with all the required content and failed to post it prominently in a conspicuous place for staff, residents, and visitors to view. 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).	0 680		

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0 680	Continued From page 9 The findings include: On September 16, 2024, at 1:32 p.m., the surveyor requested the facility's EPP. Licensed assisted living director (LALD)-D stated the EPP was not located at the facility, rather it was located at their main office; they inquired to the surveyor if it was allowed to be kept at the main office location. The surveyor explained it was required to be onsite and prominently displayed. LALD-D stated they would bring the EPP to the facility the next day (September 17, 2024). On September 17, 2024, at 12:00 p.m., the surveyor reviewed the licensee's Emergency Preparedness Plan, undated, which lacked evidence of the following required information: - annual review and update; - contracts to re-establish utility services; - development of strategies for addressing facility & community-based risks (i.e.: evacuation plans, staffing surges/shortages, back-up plans); - quarterly review of the missing resident plan; - designation of a qualified person, who is authorized in writing, to act in the absence of the administrator; - process for cooperation and collaboration with local, tribal, regional, State and Federal EP to maintain integrated response; - development and implementation of EP policies/procedures (P/P) based on the EP, risk assessment & communication plan; - shelter in place needs; - development of P/P for at minimum food, water and pharmaceutical supplies; - development of P/P for sewage and waste disposal; - development of P/P for system to track the location of on-duty staff and sheltered residents; - development of P/P for if on-duty staff and	0 680		

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0 680	Continued From page 10 sheltered residents are relocated, how the licensee must document the specific name/location of the receiving facility or other location; - development of P/P to address safe evacuation from the facility, including consideration of care/treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); primary/alternate communication means with external sources of assistance; - development of P/P for shelter in place for residents, staff, and volunteers who remain in the facility; - development of P/P for a system of medical documentation that preserves resident information, protects confidentiality, and secures/maintains availability of records; - development of P/P to address: use of volunteers, including the process/role for integration; - development of P/P to address the role of the licensee under a waiver declared by the Secretary in accordance with section 1135 of the Act; - development of a communication plan to include all of the following: method for sharing information from the emergency plan, that the facility has determined appropriate, with residents and their families/representatives; and - development of a communication plan which included: - method for sharing information and medical documentation for residents under the facility's care, as necessary, with other HCPs to maintain continuity of care; - means, in event of evacuation, to release resident information as permitted under 45 CFR 164.510(b)(1)(ii); - means of providing information about	0 680		

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0 680	Continued From page 11 general condition/ location of residents under the facility's care as permitted under 45 CFR 164.510(b)(4); - development of a communication plan to included: - federal, state, tribal, regional & local EP staff; - state licensing and certification agency; - MN Office of Ombudsman for LTC; - other sources of assistance; - must conduct exercises to test the EP at least twice per year, including unannounced staff drills using the EP. On September 18, 2024, at 9:37 a.m., LALD-D stated the EPP was missing required information, and they were not entirely familiar with all requirements. The licensee's Emergency Preparedness policy dated May 26, 2020, indicated, "[Licensee] will have an identified plan in place to assure the safety and well-being of clients and staff during periods of an emergency or disaster that disrupts services." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of	0 730		

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	35138	A. BUILDING: _____ B. WING _____	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER HOME CARE LLC	7120 13TH AVENUE SOUTH RICHFIELD, MN 55423

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0 730	Continued From page 12 the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or	0 730		

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0 730	Continued From page 13 status. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the resident record included a discharge summary with required content for one of one discharged resident (R1). Further, the licensee failed to ensure documentation of services provided as identified on the service plan for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted to the licensee on May 25, 2022, and discharged on February 27, 2024. R1's Discharge Summary dated February 27, 2024, unsigned, lacked a final summary of the resident's status from the latest assessment or review under Minnesota Statutes, section 144G.70, including baseline and current mental, behavioral, and functional status. R2 R2 was admitted to the licensee on November 9, 2020. R2's Service Plan dated November 9, 2023,	0 730		

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0 730	Continued From page 14 indicated R2 received services for homemaking, shopping, money management, assistance making appointments, arrange non-medical appointments, individual staff ratio 1:1, meal preparation, assistance with dressing, assistance with grooming, assistance with bathing, medication management, wandering, anxiety, agitation, verbal aggression, physical aggression, and cognitive health. R2's record lacked documentation of services provided. On September 17, 2024, at 11:19 a.m., the surveyor observed unlicensed personnel (ULP)-B assist R2 with a blood glucose (BG) check and Novolog Flexpen insulin administration. On September 16, 2024, at 1:32 p.m., licensed assisted living director (LALD)-D and clinical nurse supervisor (CNS)-A stated they did not document when a service was provided for any of their residents. LALD-D stated they did not know they had to document services when provided. LALD-D inquired if service documentation was in the statutes. On September 16, 2024, at 1:36 p.m., the surveyor provided, and read aloud, the statute language from the Home Care & Assisted Living Laws & Rules statute book 144G.43 Subd. 3. to LALD-D and CNS-A, "documentation that services have been provided as identified in the service plan,"; both stated they now understood the statutory requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		

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0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms outside, in the immediate vicinity of sleeping rooms on both levels and failed to provide a resident bedroom with the minimum egress well size, meeting the minimum state standard for egress. This affected all staff and residents. This practice resulted in a level two violation (a	0 780		

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0 780	Continued From page 16 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On September 17, 2024, at 10:30 a.m., survey staff toured the facility with the administrator(A)-C. During the tour, it was observed a smoke alarm was not installed immediately outside of sleeping rooms 1, 2 and 3 on the main level, and sleeping rooms 4 and 5 on the lower level. During the interview on September 17, 2024, at 11:00 a.m., A-C stated smoke alarm was not installed immediately outside of sleeping rooms on both levels. It was observed the occupied resident bedroom 4 on the lower level did not have egress window well that met the minimum size requirement for egress escape. The window well measured 26 inches in depth and 41 inches in width with a total well area of 1,066 square inches. The egress window well did not meet the requirements for egress well size. Egress window well in existing sleeping room must have a minimum egress window well depth of 36 inches and minimum width of 36 inches with no less than 1,296 square inches total area. Survey staff explained to A-C that the egress well need to meet the minimum size requirement and A-C verbally confirmed the findings.	0 780		

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0 780	Continued From page 17 TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to perform the required annual and monthly maintenance on fire extinguishers as required. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 790		

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0 790	Continued From page 18 The findings include: On September 17, 2024, at 10:30 a.m., survey staff toured the facility with the administrator(A)-C. During the facility tour, it was observed that the fire extinguisher did not have a service tag, showing it had been inspected annually, and it lacked records showing the required monthly visual inspections performed on the portable fire extinguishers. During the interview on September 17, 2024, at 11:00 a.m., A-C verified that the required maintenance had not been completed on both fire extinguishers. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents and staff.	0 800		

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0 800	Continued From page 19 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On September 17, 2024, at 10:30 a.m., survey staff toured the facility with the administrator(A)-C. During the facility tour, survey staff observed the following items: In resident sleeping room 4 on the lower level, it was observed that the wood veneer on the door was detached and hanging loose. It was also observed that a heavy metal grate well cover was installed over the egress well, which was affixed to one side. The well cover was heavy and difficult to open, and the emergency egress was obstructed. In the living room on the lower level, it was observed that the ceiling-mounted supply air grille cover was not securely mounted, with missing screws and sharp edges exposed. In the bathroom on the main level, it was observed that the exhaust fan was broken, and the cover was missing. During the interview on September 17, 2024, at 11:00 a.m., A-C visually verified these deficient findings at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7)	0 800		

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0 800	Continued From page 20 days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.	0 810		

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0 810	Continued From page 21 This MN Requirement is not met as evidenced by: Based on the interview and record review, the licensee failed to develop the fire safety and evacuation plan with the required content, failed to provide the required training, and failed to provide the required drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On September 17, 2024, at 11:30 a.m., administrator(A)-C provided documentation on the fire safety and evacuation plan (FSEP), fire safety and evacuation training for the facility, and fire safety and evacuation drills for the facility. EMERGENCY EVACUATION PLAN On the facility tour with the A-C on September 17, 2024, at 10:30 a.m., it was observed that the posted fire safety and evacuation plans on both levels did not accurately depict the actual layout of the facility. The sleeping room locations shown in the evacuation plans did not match the current locations, and the egress routes shown on both levels did not match the facility's egress procedures. This deficient condition was visually verified by A-C accompanying the tour, and confirmed the	0 810		

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0 810	Continued From page 22 posted evacuation plans did not accurately depict the actual layout of the sleeping room layout, emergency exit route, and exit door locations. FIRE SAFETY AND EVACUATION PLAN The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The FSEP included the RACE (Remove, Alarm, Confine, and Extinguish or Evacuate) acronym as the fire safety procedure and instructed staff to pull the nearest fire alarm in case of fire, but the facility did not have a fire alarm system. The FSEP plan also included ensuring a sprinkler system is installed and functional, but the facility did not have a sprinkler system installed. The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan failed to include ways to move, evacuate residents based on the facility's specific layout in the event of a fire or similar emergency. Record review of the available documentation indicated that the licensee did not have fire protection procedures necessary for residents included in the fire safety and evacuation plan. During the interview on September 17, 2024, at 12:00 p.m., A-C stated the fire safety and evacuation plan was from a third-party provider and verified the facility needed to update the fire safety and evacuation plan, including the facility-specific fire safety protocols. A-C also	0 810		

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0 810	Continued From page 23 confirmed that the facility had not developed the necessary fire protection procedures for residents. TRAINING Record review of the available documentation indicated employees did not receive training twice yearly after initial hire. In the provided FSEP, the facility policy required the staff training to be conducted at orientation and annually after. Employee training records were requested, and no training records were provided. During the interview on September 17, 2024, at 12:00 p.m., A-C stated that the facility provided one fire safety training and evacuation at new hire orientation, and the staff training record would be provided via email as a follow-up. But no follow-up email has been received from the facility. DRILLS Record review of the available documentation indicated that the licensee did not conduct evacuation drills twice per year per shift and every other month as required by statute. Provided documentation indicated that the drills were conducted on 12/27/23 at 4:15 p.m., 2/25/24 at 9:00 a.m., 4/25/24 at 7:25 a.m., 6/24/24 3:30 p.m., and 8/23/24 4:00 p.m., with no further drills being documented. During the interview on September 17, 2024, at 12:00 p.m., A-C confirmed that the licensee did not conduct evacuation drills every other month and confirmed that the facility did not conduct two drills for the night shifts. A-C verified that there were no further documented drills for the facility for the year.	0 810		

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0 810	Continued From page 24 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 820 SS=I	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide a resident bedroom with the minimum window opening meeting the minimum state standard for egress. This affected the occupied resident in bedrooms 1, 2 and 3 on the main level and bedroom 4 on the lower level. 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 a widespread scope (when problems are pervasive or represent a systemic failure that	0 820		

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0 820	Continued From page 25 has affected or has potential to affect a large portion or all of the residents). The findings include: On September 17, 2024, at 10:30 a.m., survey staff toured the facility with the administrator(A)-C. During the tour, survey staff asked A-C to open the windows in the resident bedrooms for measurement. The noncompliant measurements were as follows: It was observed that occupied resident bedrooms 1 and 2 on the main level did not have windows that met the minimum size requirements for egress escape. The clear openable area of the opened windows measured 20 inches in height and 23 inches in width, with a total openable area of 460 square inches. The windows did not meet the minimum requirements for total openable area. It was observed that occupied resident bedroom 3 on the main level did not have windows that met the minimum size requirements for egress escape. The clear openable area of the opened windows measured 16 inches in height and 33 inches in width, with a total openable area of 528 square inches. The windows did not meet the minimum requirements for opening height and did not meet the minimum requirements for total openable area. It was observed unoccupied resident bedroom 5 on the main level did not have windows that met the minimum size requirements for egress escape. The clear openable area of the opened windows measured 38 inches in height and 18 inches in width, with a total openable area of 684 square inches. The windows did not meet the minimum requirements for opening width.	0 820		

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	35138	A. BUILDING: _____ B. WING _____	09/18/2024

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0 820	Continued From page 26 Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. Survey staff explained to A-C that at least one egress window in each bedroom must be provided to meet the minimum state standard for an egress window to be a complying bedroom for resident occupancy. A-C verbally confirmed the findings. On September 17, 2024, at 11:00 a.m., during the interview, survey staff explained to A-C that an immediate correction order was issued for the above finding. A-C acknowledged the above finding. No Further information was provided. TIME PERIOD FOR CORRECTION: Immediate.	0 820		
0 970 SS=F	144G.50 Subd. 5 Waivers of liability prohibited 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. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the	0 970		

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0 970	Continued From page 27 licensee's liability for health, safety, or personal property of a resident for one of one resident (R2). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On September 16, 2024, at 11:47 a.m., the surveyor reviewed the licensee's blank Assisted Living Contract, undated, which included the following waivers of liability: "Insurance Liability and Release. The resident shall maintain at all times his or her own health, personal property, liability, automobile (if applicable), and other insurance coverages and shall provide evidence of same by copies of binders or policies provided to [licensee] upon request. The resident acknowledges that [licensee] is not an insurer of the resident's person or property. The resident agrees that [licensee] will not be liable to the resident for any personal injury or property damage (including, without limitation, damage to, or loss or theft of, automobiles or personal property of resident) suffered by the resident or the resident's agents, guests or invitees, unless and to the extent that the injury or damage is caused by the negligence of [licensee] or its employees or agents. The resident hereby releases [licensee] from liability for any personal injury or property damage suffered by the resident or the resident's agents, guests, or invitees, unless caused by the	0 970		

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0 970	Continued From page 28 negligence of [licensee] or its employees or agents. Indemnification: [Licensee] shall not be liable for any damage or injury to the resident, or any other person, or to any property, occurring on the premises, or any part thereof, or in common areas thereof, and the resident agrees to hold [licensee] harmless from any claims or damages unless caused solely by negligence of [licensee]. It is recommended that renter's insurance be purchased at the resident's expense. Nothing contained herein is intended to create a waiver of facility liability for the health and safety or personal property of a resident." R2 was admitted on to the licensee on November 9, 2020. R2's record included the same Assisted Living Contract as the above-mentioned blank contract signed on November 9, 2023. On September 18, 2024, at 9:37 a.m., licensed assisted living director (LALD)-D stated they were not aware a waiver of liability was in their contract. LALD-D stated they received the contract from a consulting company and thought it was okay to use. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01460 SS=F	144G.63 Subdivision 1 Orientation of staff and supervisors All staff providing and supervising direct services must complete an orientation to assisted living	01460		

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01460	Continued From page 29 facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employees received orientation to assisted living statutes for one of two direct care employees (clinical nurse supervisor (CNS)-A, unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: CNS-A CNS-A was hired by the licensee on June 6, 2022, to provide clinical duties and oversight to unlicensed personnel. ULP-B ULP-B was hired by the licensee on January 16, 2024, to provide direct care services for residents. CNS-A and ULP-B's employee record included an	01460		

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01460	Continued From page 30 Educare (online training platform) transcript which lacked the following required orientation training: -Overview of Assisted Living statutes; -Review of provider's policies and procedures; -Assisted Living Bill of Rights; -Handing of resident complaints, reporting of complaints, where to report; -Consumer advocacy services; -Review of types of Assisted Living services the employee will provide and provider's scope of license; -Principles of person-centered planning/service delivery; and -Hearing loss training (optional). CNS-A and ULP-B's employee record included an Educare transcript indicated they received the following home care topics: -Home Care Bill of Rights; -Home Care orientation; and -Vulnerable Adult training for home care based services. On September 17, 2024, at 11:19 a.m., the surveyor observed ULP-B administer R2's medications. ULP-B stated they thought they had completed all of the required orientation trainings. On September 18, 2024, at 9:37 a.m., licensed assisted living director (LALD)-D stated they were in charge of assigning Educare training and was not aware they were using some of the wrong trainings which addressed home care regulations instead of assisted living regulations. LALD-D stated they thought the assigned trainings covered the appropriate topics. On September 18, 2024, at 11:01 a.m., CNS-A stated training was assigned in Educare by LALD-D. CNS-A stated they completed training	01460		

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01460	Continued From page 31 topics in the area of home care but not assisted livings. CNS-A stated Educare is where all of their training was completed. The licensee's Staff Orientation and Education policy dated May 26, 2020, referenced home care regulations and indicated: "3. Orientation topics will include, but not be limited to, the following a. Overview of Minnesota Home Care Statute Sections 144A.43 to 144A.4798 b. Review of the employee's job description and responsibilities c. Review of the organization's policies and procedures related to the provision of home care services by the staff member d. Handling of emergencies and the use of emergency services e. Compliance with Minnesota's Vulnerable Adult/Minor Acts (Sections 626.556 and 626.557) and specific requirements per organizational policy, including information on common entry point f. Home Care Bill if Rights g. Grievance Policy/Process h. Consumer advocacy services, including i. Office of Ombudsman for Long-Term-Care ii. Office of Ombudsman for Mental Health iii. Office of Ombudsman for Developmental Disabilities iv. Managed Care Ombudsman at the Department of Human Services v. County managed care advocates vi. Other advocacy services i. Organization's Scope of Services." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	01460		

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01460	Continued From page 32 (21) days	01460		
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a),	01500		

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01500	Continued From page 33 annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employees received at least eight hours of annual training for each 12 months of employment on required annual training topics for one of two employees (clinical nurse supervisor (CNS)-A). 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).	01500		

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01500	Continued From page 34 The findings include: CNS-A was hired by the licensee on June 6, 2022, to provide clinical duties and oversight to unlicensed personnel. CNS-A's employee record included an Educare (online training platform) transcript included training completed on June 2, 2024, through June 6, 2024. CNS-A's record lacked annual training since their date of hire on June 6, 2022, in the following annual training topics: -Overview of Assisted Living statutes; -Review of provider's policies and procedures; and -Principles of person-centered planning/service delivery. On September 18, 2024, at 9:37 a.m., licensed assisted living director (LALD)-D stated they were in charge of assigning Educare training and were not aware they were using some of the wrong trainings which addressed home care regulations and requirements instead of assisted living regulations. LALD-D stated they thought the assigned trainings covered the required annual training topics. On September 18, 2024, at 11:01 a.m., CNS-A stated training was assigned in Educare by LALD-D. CNS-A stated they completed training topics in the area of home care but not assisted livings. CNS-A stated they recently got caught up on some annual training. CNS-A stated Educare is where all of their training was completed. The licensee's Staff Orientation and Education policy dated May 26, 2020, indicated: "10. All staff providing direct home care will complete at least eight (8) hours of education for	01500		

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01500	Continued From page 35 every twelve (12) months of employment. 11. Education topics will include, but not be limited to, the following a. Reporting of maltreatment of adults or minors b. Review of Home Care Bill if Rights c. Review of the organization's policies and procedures related to implementation of home care services d. Infection control techniques used in the home i. Implementation of infection control standards based on current recommendations per the CDC**** ii. Hand washing iii. Need for/use of personal protective equipment (PPE) iv. Appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes and razor blades v. Disinfection of reusable equipment vi. Disinfection of environmental surfaces vii. Reporting of communicable diseases." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
01530 SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter;	01530		

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01530	Continued From page 36 (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 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; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide employees with the initial eight (8) hours of dementia training within 120 hours for one of one supervisor (clinical nurse supervisor (CNS)-A) of direct care staff and within 160 hours of providing direct care to residents for one of one direct care employee (unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	01530		

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01530	Continued From page 37 CNS-A CNS-A was hired by the licensee on June 6, 2022, to provide clinical duties and oversight to unlicensed personnel. CNS-A's employee record included an Educare (online training platform) transcript which included 4.5 hours of initial dementia training completed on June 2, 2024. CNS-A's record was short of the required eight hours of initial dementia training. ULP-B ULP-B was hired by the licensee on January 16, 2024, to provide direct care services for residents. ULP-B's employee record included an Educare transcript which included 4.5 hours of initial dementia training. ULP-B's employee record also included a Certificate of Completion dated August 15, 2024, which included one hour of dementia training. ULP-B's record was short of the required eight hours of initial dementia training. On September 18, 2024, at 9:37 a.m., licensed assisted living director (LALD)-D stated they were in charge of assigning trainings to employees. LALD-D stated they did not realize CNS-A and ULP-B were short on initial dementia training hours until it was pointed out to them by the surveyor. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		

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01880	Continued From page 38	01880		
01880 SS=D	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to monitor the temperature of their medication storage refrigerator to ensure medications were stored according to manufacturer directions for one of one resident (R2) with refrigerated medications. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 was admitted to the licensee on November 9, 2020, and had a diagnosis of diabetes. R2's Service Plan dated November 19, 2023, indicated R2 received medication management assistance. R2's Med Admin Summary (medication administration record (MAR)) for September 2024, indicated R2 took the following medications:	01880		

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01880	Continued From page 39 -Lantus Solostar 100 units (u)/milliliter (ml) injection, inject 65u subcutaneously (SQ) at bedtime; -Novolog Flexpen 100u/ml injection; inject 10u SQ before breakfast and then 15u before lunch and supper; and -Victoza 18mg/3ml injection, inject 0.3ml (1.8mg) daily SQ. On September 17, 2024, at 11:19 a.m., the surveyor observed unlicensed personnel (ULP)-B assist R2 with a blood glucose (BG) check and Novolog Flexpen insulin administration. On September 16, 2024, at 12:42 p.m., the surveyor observed the locked medication refrigerator with clinical nurse supervisor (CNS)-A. The surveyor observed the thermometer in the refrigerator which read 55 degrees Fahrenheit (F). CNS-A stated they did not know if they had a temperature log for the refrigerator and did not know they needed to monitor the temperature. Licensed assisted living director stated they did not have a temperature log for the refrigerator. The surveyor observed there was ice buildup in the refrigerator near the insulin pens. The surveyor observed the following medications in the refrigerator for R2: -Novolog Flexpen 100u/ml injection; seven boxes of four pens and one-half box of two pens; and -Victoza 18mg/3ml injection, five boxes of two pens. Manufacturer instructions for Lantus, last revised on June 2023, indicated store unused Lantus in a refrigerator between 36-46 degrees F; discard if Lantus has been frozen. Manufacturer instructions for Novolog (insulin aspart), last revised in March 2023, indicated to	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35138	A. BUILDING: _____ B. WING _____	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER HOME CARE LLC	7120 13TH AVENUE SOUTH RICHFIELD, MN 55423

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01880	Continued From page 40 store unused vials in the refrigerator at 36-46 degrees F; do not freeze and do not use if it has been frozen. Manufacturer instructions for Victoza, last updated May 2024, indicated to store new, unused Victoza pens in the refrigerator at 36 degrees F to 46 degrees F; do not freeze Victoza. The licensee's Storage/Control of Medications policy dated May 29, 2020, indicated, "Medications requiring refrigeration are clearly labeled and stored in an enclosed container or area separated from foods. Temperature is maintained at 35-40 degrees." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were labeled with an opened-on date for one of one residents (R2) with insulin. This practice resulted in a level two violation (a	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35138	A. BUILDING: _____ B. WING _____	09/18/2024

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PREMIER HOME CARE LLC	7120 13TH AVENUE SOUTH RICHFIELD, MN 55423

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01890	Continued From page 41 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 was admitted to the licensee on November 9, 2020, and had a diagnosis of diabetes. R2's Service Plan dated November 19, 2023, indicated R2 received medication management assistance. R2's Med Admin Summary (medication administration record (MAR)) for September 2024, indicated R2 took the following medications: -Lantus Solostar 100 units (u)/milliliter (ml) injection, inject 65u subcutaneously (SQ) at bedtime; -Novolog Flexpen 100u/ml injection; inject 10u SQ before breakfast and then 15u before lunch and supper; and -Victoza 18mg/3ml injection, inject 0.3ml (1.8mg) daily SQ. On September 17, 2024, at 11:19 a.m., the surveyor observed unlicensed personnel (ULP)-B assist R2 with a blood glucose (BG) check and Novolog Flexpen insulin administration. R2's Novolog Flexpen was unlabeled with an opened-on date or prescription label. On September 16, 2024, at 12:49 p.m., the surveyor observed R2's medication bin in the	01890		

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	35138	A. BUILDING: _____ B. WING _____	09/18/2024

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01890	Continued From page 42 medication storage cabinet with clinical nurse supervisor (CNS)-A, which contained three insulin injection pens including a Lantus Solostar pen, Novolog Flexpen, and a Victoza pen. The three insulin pens lacked opened-on dates and prescription labels. CNS-A stated it was the responsibility of the person who opened the new insulin pen to label it with an opened-on date. CNS-A stated they were aware insulin pens could only be unrefrigerated for a certain number of days depending on the type of insulin. CNS-A stated the insulin pen did not have a prescription label as the pharmacy would not put one on the individual pens since they came in a box with multiple pens. CNS-A stated they could request additional prescription labels from the pharmacy. The manufacturer instructions for Lantus Solostar insulin pens revised on December 2020, indicated once a Solostar pen was taken out of cool storage for use it can be used for up to 28 days. The manufacturer instructions for Novolog FlexPen 3ml prefilled pen revised February 2023, indicated it should be thrown away after 28 days of being opened or unrefrigerated, even if it still has insulin left in it. The manufacturer's instructions for Victoza insulin pens updated on May 2024, indicated to only use a Victoza pen for 30 days and then should be discarded even if some medicine is left in the pen. The licensee's Storage/Control of Medications policy dated May 29, 2020, indicated: "2. The medication is labeled completely and legibly. The medication label should contain the following.	01890		

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	35138	A. BUILDING: _____ B. WING _____	09/18/2024

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PREMIER HOME CARE LLC	7120 13TH AVENUE SOUTH RICHFIELD, MN 55423

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01890	Continued From page 43 a. Prescription number and name of medication b. Strength and quantity c. Expiration date for time-dated drugs d. Directions for use e. Resident's name f. Prescriber's name g. Date issued h. Name and address of licensed pharmacy issuing the medication 3. The licensed nurse is responsible for dating time-sensitive medications when opened." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35138	A. BUILDING: _____ B. WING _____	09/18/2024

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01910	Continued From page 44 individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide documentation in the resident's record regarding the disposition of medication to include the prescription number, quantity, and to whom the medications were given for one of one discharged resident (R1). 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). R1 was admitted to the licensee on May 25, 2022, and discharged on February 27, 2024. R1's Service Plan dated May 24, 2023, indicated R1 received services for medication management. R1's Discharge Summary dated February 27, 2024, unsigned, included a list of R1's mediations at discharge but lacked prescription number, quantity, and to whom the medications were given: -aripiprazole 30 milligram (mg) tablet, take one tablet by mouth (PO); -benztropine 1mg tablet, take one tablet PO at bedtime; -divalproex 500mg extended release (ER) tablet, take two tablets twice a day PO; -gabapentin 300mg capsule, take one capsule	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01910	Continued From page 45 PO three times daily as needed (PRN); -nicotine gum 2mg, chew one piece every hour while awake PRN; -propranolol 20mg tablet, take one tablet PO twice a day; -sertraline 100mg tablet, take two tablets PO every morning; and -trazodone 50mg tablet, take one tablet PO at bedtime. On September 18, 2024, at 9:37 a.m., licensed assisted living director (LALD)-D stated they did not know all of the medication disposition requirements for discharged residents. On September 18, 2024, at 11:01 a.m., clinical nurse supervisor (CNS)-A stated they sent R1's medications with them since they were medications the resident paid for. CNS-A stated they were not aware of all required medication disposition information required. The licensee's Disposition/Disposal of Medications policy dated May 29, 2020, indicated: "Upon disposition, Premier Home Care will document the following information in the clinical record a. Name, strength and prescription number of medication, as applicable b. Quantity c. Method of disposition or to whom the medications were given d. Date of disposition e. Name(s)/signature(s) of staff involved in disposition." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		

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

Type: Full
Date: *09/16/24*
Time: 12:30:27
Report: 1050241194

Food and Beverage Establishment Inspection Report

Location:
Premier Home Care Llc
7120 13th Avenue South
Richfield, MN55423
Hennepin County, 27

Establishment Info:
ID #: 0038100
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6128861890
ID #:

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

The following orders were issued during this inspection.

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

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

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

OBSERVED EGGS STORED OVER RTE FOODS IN THE REACH-IN COOLER. DISCUSSED SEPARATION REQUIREMENTS TO PREVENT CONTAMINATION. COMPLY WITH RULE ABOVE.

Comply By: 09/16/24

3-500C Microbial Control: date marking

3-501.17A ***** Priority 2 *****

MN Rule 4626.0400A Mark the refrigerated, ready-to-eat, TCS food prepared and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded.

OBSERVED CONTAINER OF PICO INSIDE REACH IN COOLER NOT PROPERLY LABELED. DISCUSSED REQUIREMENTS AND MARKING ITEMS WITH DISCARD DATE.

Comply By: 09/16/24

4-600 Cleaning Equipment and Utensils

4-601.11B

MN Rule 4626.0840B Maintain the food contact surfaces of cooking equipment and pans free of encrusted grease deposits and other soil accumulations.

OBSERVED CONVECTION OVEN INTERIOR FOUND WITH ENCRUSTED FOOD DEBRIS THROUGHOUT CAVITY. CLEAN AND MAINTAIN CLEAN. COMPLY WITH RULE ABOVE.

Comply By: 09/16/24

4-600 Cleaning Equipment and Utensils

4-602.12

MN Rule 4626.0850 Clean the food contact surfaces of cooking and baking equipment and interior cavities of microwave ovens at least every 24 hours.

OBSERVED INSIDE OF MICROWAVE WITH FOOD DEBRIS BUILD UP ON THE INSIDE. DISCUSSED CLEANING FREQUENCY TO PREVENT THIS FROM OCCURRING COMPLY WITH RULE ABOVE.

Comply By: 09/16/24

Surface and Equipment Sanitizers

Hot Water: = at 165F Degrees Fahrenheit
Location: Dishewasher
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding/Milk
Temperature: 37F Degrees Fahrenheit - Location: Reach-In Cooler
Violation Issued: No

Process/Item: Cold Holding/Lettuce
Temperature: 39F Degrees Fahrenheit - Location: Reach-In Cooler
Violation Issued: No

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

Inspection was completed by MDH Andrew Spaulding and the Jabrail Yusef. Joey Keen was the lead Health Regulation Division Nurse Evaluator.

This establishment has a residential kitchen. Food must be prepared for same day service only. The kitchen has wood cabinets with a hollow base and wood flooring. All found to be in good condition.

Discussed the following:
-Employee illness policy and logging requirements
-Hand Washing
-Glove-use and bare hand contact
-Food storage and preventing cross contamination
-Date marking
-Vomit clean up procedures
-Restrictions concerning serving a highly susceptible population

Type: Full
Date: *09/16/24*
Time: 12:30:27
Report: 1050241194
Premier Home Care Llc

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department Of Health inspection report number 1050241194 of 09/16/24.

Certified Food Protection Manager: Jibrail Yusef

Certification Number: FM100873 Expires: 12/01/24

Inspection report reviewed with person in charge and emailed.

Signed:_____

Jibrail Yusef
Operator

Signed:_____

Andrew Spaulding
Public Health Sanitarian 2
FPLS Metro
651-201-5298
andrew.spaulding@state.mn.us