Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

July 15, 2024

Licensee
Deephaven Woods Senior Living
18025 Minnetonka Boulevard
Deephaven, MN 55391

RE: Project Number(s) SL30474015

Dear Licensee:

On June 20, 2024, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on July 19, 2023. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the July 19, 2023 survey.

The Department of Health 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.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on July 19, 2023, found not corrected at the time of the June 20, 2024, follow-up survey and/or subject to penalty assessment are as follows:

0810-Fire Protection And Physical Environment-144g.45 Subd. 2 (b)-(f) - $500.00

The details of the violations noted at the time of this follow-up survey completed on June 20, 2024 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

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

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

IMPOSITION OF FINES:

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.

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.

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.

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

REQUESTING A HEARING

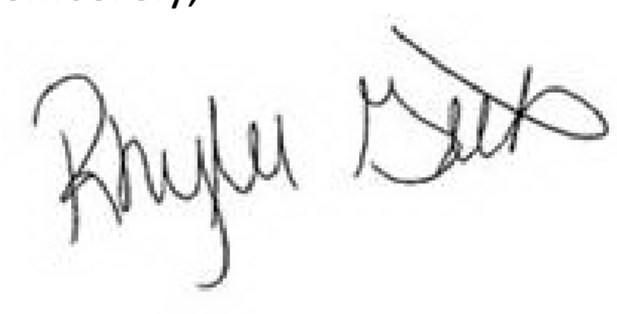
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for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

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

We urge you to review these orders carefully. If you have questions, please contact Rhylee Gilb at 218-232-8285.

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

Sincerely,



Rhylee Gilb, Supervisor
State Rapid Response Team
Email: Rhylee.Gilb@state.mn.us
Telephone: 218-232-8285 Fax: 1-800-337-9238

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30474	A. BUILDING: _____ B. WING _____	R 06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEEPHAVEN WOODS SENIOR LIVING	18025 MINNETONKA BOULEVARD DEEPHAVEN, MN 55391

(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 On June 11 2024, the Minnesota Department of Health conducted a licensing order follow-up related to correction orders issued for SL30474015-1. The following correction order is re-issued for SL30474015-1 , tag identification 0810.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment	{0 810}		

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

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{0 810}	Continued From page 2 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 the potential to affect a large portion or all of the residents). The findings include: The facility provided staff training record of completed fire training dated June 15, 2023 through May 20, 2024, lacked evidence staff received fire safety training twice a year. The facility provided log of fire drills dated December 28, 2023 through March 6, 2024, lacked evidence of fire drills performed in April 2024 and May 2024. Email communication with the Licensed Assisted Living Director on June 11, 2023, at 11:16 a.m., stated staff are to receive fire safety training annually. Facility Policy "Emergency Preparedness Manual - Fire Safety Plan" dated August 2022 incorrectly indicated staff will be trained annually on fire plan protocol. The same policy indicated at least one scheduled fire drill per shift will be held each month.	{0 810}		

Electronically Delivered

August 15, 2023

Licensee
Deephaven Woods Senior Living
18025 Minnetonka Boulevard
Deephaven, MN 55391

RE: Project Number(s) SL30474015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 19, 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 - 0510 - 144g.41 Subd. 3 - Infection Control Program = $500.00

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

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

The correction order documentation should include the following:

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

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

Casey DeVries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 Fax: 651-281-9796

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30474	A. BUILDING: _____ B. WING _____	07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEEPHAVEN WOODS SENIOR LIVING	18025 MINNETONKA BOULEVARD DEEPHAVEN, MN 55391

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0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30474015-0 On July 17, 2023, through July 19, 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 83 active residents; 54 of whom received services under the Assisted Living with Dementia Care license.	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.	
0 450 SS=C	144G.41 Subdivision 1 Minimum requirements All assisted living facilities shall: (1) distribute to residents the assisted living bill of	0 450		

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0 450	Continued From page 1 rights; (2) provide services in a manner that complies with the Nurse Practice Act in sections 148.171 to 148.285; (3) utilize a person-centered planning and service delivery process; (4) have and maintain a system for delegation of health care activities to unlicensed personnel by a registered nurse, including supervision and evaluation of the delegated activities as required by the Nurse Practice Act in sections 148.171 to 148.285; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide the current assisted living bill of rights (BOR) to four of four residents (R2, R3, R4, and R5). 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). The findings include: R2 R2 was admitted on August 1, 2021. The licensee's current resident roster indicated R2 received housing services only. On August 1, 2021, R2 signed assisted living contract. The contract indicated the BOR was included as attachment G.	0 450		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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0 450	Continued From page 2 R2's record lacked evidence R2 had received the current assisted living BOR. R3 R3 was admitted and began receiving assisted living services on December 14, 2022. On December 8, 2022, R3's BOR acknowledgement was signed. R3's record lacked evidence R3 had received the current assisted living BOR. R4 R4 admitted for services under the comprehensive home care license on July 18, 2019, and began receiving assisted living services on August 1, 2021. On December 8, 2022, R4's BOR acknowledgement was signed. R4's record lacked evidence R4 had received the current assisted living BOR. R5 R5 was admitted and began receiving assisted living services on May 2, 2022. On April 29, 2023, R5's BOR acknowledgement was signed. R5's record lacked evidence R5 had received the current assisted living BOR. The acknowledgement forms in the records of R2, R3, R4, and R5 did not clearly indicate the version date of the BOR they received. On July 17, 2023, at approximately 11:00 a.m.,	0 450		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 450	Continued From page 3 licensed assisted living director (LALD)-D, presented surveyors with a blank resident admission folder containing a copy of the BOR they were currently using. That version was dated July 26, 2022. As of July 18, 2023, the most current version of the assisted living BOR was dated November 8, 2022. On July 18, 2023, at 11:30 a.m., Licensed Assisted Living Director (LALD)-D acknowledged the BORs in resident records were not the current version. LALD-D stated they were not aware the current version of the BOR had not been distributed to residents prior to LALD-D starting their position with licensee on July 10, 2023. LALD-D stated licensee would need to distribute the current version of the BOR and obtain clear acknowledgement to ensure this was completed. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 450		
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	0 480		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 480	Continued From page 4 prepared according to the Minnesota Food Code. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Please refer to the additional documentation included in the Food and Beverage Establishment Inspection Reports, dated July 18, 2023. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced	0 510		

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0 510	Continued From page 5 by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program that complied with accepted health care, medical, and nursing standards for infection control related to gloving, and hand hygiene for four of four employees (unlicensed personnel (ULP)-E, ULP-F, ULP-I, and ULP-N). 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: ULP-E ULP-E was hired on February 1, 2023, to provide assisted living services to residents. On July 17, 2023, at 10:37 a.m., the surveyor observed ULP-E without performing hand hygiene, apply gloves, administer medications to R13, and remove gloves. Without performing hand hygiene ULP-B pushed R13 in wheelchair to join the morning activity. On July 17, 2023, at 10:43 a.m., during continuous observation, the surveyor observed ULP-E without performing hand hygiene, apply gloves, and check for R6's creams in medication cart. ULP-E stated maybe the creams were in R6's bathroom. ULP-E locked the cart and still with same gloves, walked through the hallway to	0 510		

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DEEPHAVEN WOODS SENIOR LIVING	18025 MINNETONKA BOULEVARD DEEPHAVEN, MN 55391

(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
0 510	Continued From page 6 R6's room to check for the creams. In R6's room ULP-E assisted R6 to transfer into the toilet with a standing lift machine, then remove gloves and put on a clean pair before washing hands. Once R6 was ready, ULP-E with help of ULP-B assisted R6 to a standing position with the standing lift machine. Then, using the same gloves, ULP-E applied the cream to R6's bottom, removed the gloves and without washing hands went back to the medication cart in dining room. On July 17, 2023, at 11:27 a.m., ULP-E stated that infection control training was provided by the licensee at the corporate office and in online training modules. ULP-E also stated they were supposed to wash hands before and after cares and when hands are soiled. ULP-F On July 18, 2023, at 7:16 a.m., during continuous observation, the surveyor observed ULP-F perform hand hygiene and apply gloves. ULP-F obtained R14's clothing, guided R14 to the bathroom to sit on the toilet and removed incontinence pullup soiled with stool. Without performing hand hygiene or change of gloves, ULP-F applied a new in incontinence pull up and pants to R14's knees, removed night gown, washed R14's underarms, chest, and back, and removed gloves. Without performing hand hygiene, ULP-F applied a new pair of gloves, dried R14's underarms, chest, and back, applied deodorant, lotion, and shirt, stood R14 and provided perineal care. Without performing hand hygiene or change of gloves, ULP-F raised R14's incontinence pullup and pants, assisted with oral care, brushed R14's hair, and removed gloves. Without performing hand hygiene, ULP-F applied a new pair of gloves, made R14's bed, opened R14's blinds, placed shoes into closet, and	0 510		

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0 510	Continued From page 7 removed gloves. Without performing hand hygiene, ULP-F applied a new pair of gloves, removed trash from trash bin, replaced trash liner, exited R14's room, threw trash in room located down the hallway, and removed gloves. On July 18, 2023, at 7:40 a.m., during continuous observation, the surveyor observed ULP-F enter a married couple's room (R3 and R12) without performing hand hygiene between residents. ULP-F applied gloves, assisted R12 with transfer, guided R12 to the bathroom, lowered R12's incontinent pullup and pants, assisted R12 to sit on toilet, removed R12's shirt, and removed gloves. Without performing hand hygiene, ULP-F washed and dried R12's face, underarms, back, and chest, applied deodorant, dressed R12's upper body and removed gloves. Without performing hand hygiene, ULP-F proceeded to the kitchen, used a paper towel to wipe sweat off their face and threw paper towel away in bathroom. Without performing hand hygiene, ULP-F applied a new pair of gloves, removed R12's pants, socks, and soiled incontinent pullup. Without performing hand hygiene, ULP-F applied a new incontinent pull up, pant, socks, and shoes to R12, assisted R12 to stand, provided perineal cares and raised pants and incontinent pullup, set up oral care, brushed R12's hair and removed gloves. Without performing hand hygiene ULP-F proceeded to the kitchen, again grabbed a paper towel, and wiped off their face. Without performing hand hygiene, ULP-F assisted R12 with ambulation from the bathroom to the living room and sat R12 on the living room chair. R3 ambulated independently to the bathroom. Without performing hand hygiene, ULP-F applied a new pair of gloves, offered R3 clothing to wear, provided it to R3 at the bathroom sink, and removed R3's soiled incontinent pullup. Without	0 510		

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0 510	Continued From page 8 performing hand hygiene or change of gloves, ULP-F removed R3's pants, applied a new incontinent pullup and pants to R3's knees, and removed gloves. Without performing hand hygiene, ULP-F opened blinds, applied a new pair of gloves, made R12's bed, reminded R3 to change shirt, set up R3's toothbrush, made R3's bed, gave R12 a cell phone, and removed gloves. Without performing hand hygiene, ULP-F went to kitchen and wiped off their face with a paper towel. Without performing hand hygiene, ULP-F applied a new pair of gloves, assisted R3 with hearing aid, assisted R12 with hearing aid, and removed gloves. Without performing hand hygiene, ULP-F applied a new pair of gloves organized R3 and R12's room, removed trash, exited R3 and R12's room, walked down hallway, threw trash in a bin, and removed gloves. The surveyor did not observe ULP-F perform hand hygiene throughout the observation. On July 18, 2023, at 10:22 a.m., ULP-F stated they were trained on infection control including hand washing and gloving through a computer program followed by a nurse evaluating them. The surveyor inquired when they were trained to perform hand hygiene. ULP-F stated when you start cares and when you are done. The surveyor inquired when they would perform hand hygiene with glove use. ULP-F stated they were trained to perform hand hygiene before glove application and after glove removal. The surveyor inquired why they did not perform hand hygiene with glove changes. ULP-F stated they knew they had to perform hand hygiene initially however, they did not know they had to with each glove change if they were working with the same resident. ULP-I ULP-I was hired on January 29, 2019, to provide	0 510		

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0 510	Continued From page 9 assisted living services to residents. On July 18, 2023, at 8:20 a.m., during continuous observation, the surveyor observed ULP-I without performing hand hygiene apply clean gloves. ULP-I then began assisting with morning ADLs for R5. ULP-I assisted R5 to the bathroom via wheelchair and transferred R5 to toilet via gait belt and pivot transfer. Surveyor observed ULP-I remove soiled incontinence products from R5. Without removing gloves or performing hand hygiene, ULP-I then provided oral cares to R5. ULP-I assisted R5 to standing position and provided perineal cares. Without removing gloves or performing hand hygiene, ULP-I transferred R5 back to wheelchair utilizing grab bars and gait belt. Without removing gloves or performing hand hygiene ,ULP-I then assisted R5 with placing hearing aids and glasses. ULP-I then removed gloves and performed hand hygiene at sink. On July 18, 2023, during continuous observation from 9:04 a.m., to 9:35 a.m., the surveyor observed ULP-I perform hand hygiene at sink and then apply clean gloves prior to assisting in serving breakfast to residents in dining area. At 9:16 a.m., ULP-I removed gloves, and without performing hand hygiene or applying new gloves sat down to provide feeding assistance to a resident in the dining area. ULP-N ULP-N was hired on May 1, 2023, to provide assisted living services to residents. On July 18, 2023, at 7:20 a.m., the surveyor observed ULP-N use hand sanitizer at the medication cart, prepare medications for R19, and administer R19's medications in R19's room. ULP-N applied gloves without performing hand	0 510		

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0 510	Continued From page 10 hygiene, got R19 crackers from her kitchen, left the room, removed gloves at the medication cart, and used hand sanitizer again. On July 18, 2023, at 7:49 a.m., ULP-N returned to the medication cart after stepping away to speak with another employee. ULP-N applied gloves without hand hygiene, cleaned standing lift machine in hallway with sanitizing cloth from purple topped container and brought standing lift into R11's room. Without changing gloves, ULP-N applied lotion to R11's legs, put on R11's pants, socks, and shoes, then assisted R11 out of bed with the standing lift. ULP-N performed peri-care with same gloves on using a wet wipe, applied incontinence brief, and pulled up R11's pants while R11 was in EZ Stand. After R11 was seated in wheelchair, ULP-N set up toothbrushing supplies in the bathroom for R11 to brush teeth at the sink. ULP-N removed gloves, applied a new pair of gloves without hand hygiene, made the bed, picked up dirty clothes, and put together garbage bags. ULP-N removed gloves, took garbage out of room, and disposed of it in a room behind the elevator, then used hand sanitizer back at the medication cart. On July 18, 2023, at 12:48 p.m., clinical nurse supervisor (CNS)-C stated employees were trained to wash their hands or use hand sanitizer unless hands visibly soiled upon entering and exiting a room, in-between glove changes, or moving from a contaminated body site to a clean site. The surveyor inquired if the licensee held random audits for infection control. CNS-C stated, "I don't think we conduct audits." In addition, CNS-C stated they recently conducted a training on infection control and all employees received training annually.	0 510		

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0 510	Continued From page 11 The licensee's Standard Infection Control Precautions policy dated August 1, 2022, standard precautions apply to all staff when working with all clients, regardless of the clients' diagnosis or presumed infection status. Application of standard precautions include appropriate hand washing, utilization of personal protective equipment, proper handling of contaminated equipment and soiled linens, use and disposal of sharps, and devices used as an alternative to mouth-to-mouth resuscitation to reduce exposure to blood and other potentially infectious material. Also indicated hand washing is the most important way to break the chain of infection. Staff will wash hands: - after touching blood, body fluids, feces, or contaminated items (regardless of whether gloves are worn); · before putting on gloves; - immediately after gloves or gowns are removed; and · as necessary, between tasks and procedures on the same client to prevent cross-contamination of different body sites, and between all client contacts. the policy in addition indicated staff will wear clean gloves when touching blood, body fluids, feces, non-intact skin, mucous membranes, or contaminated items: · change gloves between tasks and procedures on the same client after contact with material that may contain a high concentration of microorganisms; - remove gloves promptly after use, and before touching non-contaminated items, environmental surfaces, self, or other clients; and - wash hands after removing gloves. The Centers for Disease Control's (CDC), "CDC's Core Infection Prevention and Control Practices	0 510		

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0 510	Continued From page 12 for Safe Healthcare Delivery in All Settings" dated November 29, 2022, under section 5a.2 (§ a, b, c, d, e, f) reads: 2.) Use an alcohol-based hand rub or wash with soap and water for the following clinical indications: a.) Immediately before touching a patient; b.) Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices; c.) Before moving from work on a soiled body site to a clean body site on the same patient; d.) After touching a patient or the patient's immediate environment; e.) After contact with blood, body fluids or contaminated surfaces; and f.) Immediately after glove removal. The licensee's Hand Washing policy dated August 1, 2021, read, "Hand Hygiene and Gloves: When conducting a procedure requiring the use of gloves, proper hand hygiene should be completed before donning gloves and after removing gloves." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 570 SS=C	144G.42 Subdivision 1 Display of license The original current license must be displayed at the main entrance of each assisted living facility. The facility must provide a copy of the license to any person who requests it. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee	0 570		

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0 570	Continued From page 13 failed to display the original current license at the main entrance of the assisted living facility as required. 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). The findings include: The licensee held an Assisted Living with Dementia Care licensure effective date is April 1, 2023, with an expiration date of March 31, 2024. On July 17, 2023, at approximately 10:26 a.m., the surveyor observed that the licensee had posted an expired Assisted Living Facility license at the facility's main entrance. Effective date of license posted at the front of the facility was August 1, 2021, with an expiration date July 31, 2022. On July 17, 2023, at approximately 11:09 a.m., licensed assisted living director (LALD)-D stated they had noticed the expired license, and had requested a new copy from the Minnesota Department of Health (MDH). On July 19, 2023, at 11:43 a.m., LALD-D stated they were unsure of the present location of the original license. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 570		

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0 570	Continued From page 14 (21) days	0 570		
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to update an individual abuse prevention plan (IAPP) to include the person's risk of abusing others and identify specific measures to be taken to minimize the risk of abuse to other vulnerable adults for one of four residents (R3). In addition, the licensee failed to address the resident's susceptibility to abuse and the risk of abuse to others for one of two assisted living residents (R2) not receiving services. 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	0 630		

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0 630	Continued From page 15 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: UPDATED IAPP R3 admitted for assisted living services on December 14, 2022. R3's diagnoses included hypertension, benign prostatic hyperplasia, type 2 diabetes mellitus (DM2), and end stage renal disease. R3's Service Plan Agreement with effective date of May 18, 2023, indicated R3 received assistance with blood glucose monitoring one time per day, housekeeping, laundry, insulin administration, medication administration, reminders to attend meals, monthly vital signs, redirection with wandering, set up for dressing, assistance with hearing aid placement, and bathing reminders. On July 18, 2023, from 7:40 a.m. through 8:18 a.m., during continuous observation, the surveyor observed unlicensed personnel (ULP)-F provide cares to R3 and R12. While the surveyor observed cares, R3 verbalized three sexual comments to ULP-F and surveyor. In addition, R3 made two attempts to touch ULP-F in a sexual manner, once on the buttock, and once on the breasts. ULP-F attempted to redirect R3 with each sexual comment and touch. R3's Assessments dated December 29, 2022, March 28, 2023, May 18, 2023, indicated R3 was not at risk of abusing others verbally, physically, or sexually. R3's IAPP lacked the following: - the person's risk of abusing other vulnerable adults; and	0 630		

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0 630	Continued From page 16 -statements of the specific measures to be taken to minimize the risk of abuse to other vulnerable adults. On July 18, 2023, at 11:27 a.m., ULP-F stated R3 had shown sexual behaviors for the past three shifts they had worked with them. On July 18, 2023, at 11:29 a.m., ULP-H stated R3 began displaying sexual behaviors when they changed locations in the facility. On July 18, 2023, at 11:31 a.m., registered nurse (RN)-A stated R3 changed locations on May 12, 2023. In addition, RN-A stated they knew of R3's sexual behaviors in March or April of 2023 however, they believed they improved once R3's wife [R12] moved in with them. The surveyor inquired when they would update an IAPP for a resident. RN-A stated it was built into the assessment they updated every 90 days. The surveyor inquired if they should update an IAPP if a new concern arose. RN-A stated they were unsure; however, the surveyor should ask the CNS. On July 18, 2023, at 12:53 p.m., clinical nurse supervisor (CNS)-C stated an IAPP would be updated every 90 days and with any change in vulnerability. In addition, CNS-C stated R3 displayed sexual behaviors prior to wife [R12] moving into the secured unit from the unsecured unit. The surveyor inquired why R3's last three assessments listed above lacked his potential to abuse others. CNS-C stated they did not know why it was not noted on the assessments. ASSISTED LIVING RESIDENTS NOT RECEIVING SERVICES R2 moved into licensee's building on August 1,	0 630		

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0 630	Continued From page 17 2021. R2 received housing only with no assisted living services from the licensee. R2's record lacked an individualized review or assessment of the resident's susceptibility to abuse by another individual, including other vulnerable adults, the resident's risk of abusing other vulnerable adults and statements of the specific measures to be taken to minimize the risk of abuse to that resident or other vulnerable adults. On July 18, 2023, at 12:55 p.m., LALD-D indicated via email that licensee may not have documentation of an IAPP for R2. According to LALD-D, R2's entire file had been presented to the surveyor and there was no additional information available. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 800 SS=D	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	0 800		

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0 800	Continued From page 18 by: 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 ability to affect a limited number of staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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). Findings include: On facility tour with the Environmental Services Director (ESD)-J and the Licensed Assisted Living Director (LALD)-D between approximately 12:30 PM and 4:00 PM on July 17, 2023, it was observed that the latch on the second-floor trash chute was not closing and latching as required. The part is currently on order and scheduled to be repaired but the process has been slowed by supply chain issues. This deficient condition was visually verified by ESD-J and LALD-D accompanying on the tour. Additionally, in the memory care's kitchen, utensils were unsecured in a drawer. These items are required to be in secure areas within the memory care to prevent the occurrence of potential injury to those in the facility. This deficient condition was visually verified by ESD-J and LALD-D accompanying on the tour.	0 800		

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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
0 800	Continued From page 19 TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique 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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	30474	A. BUILDING: _____ B. WING _____	07/19/2023

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0 810	Continued From page 20 This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to provide required employee training on fire safety and evacuation. This had the potential to affect all staff, residents, 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). Findings include: A record review and interview were conducted on July 17, 2023, between approximately 3:30 p.m. and 4:00 p.m. with the Licensed Assisted Living Director (LALD)-D and the Environmental Service Director (ESD)-J on the fire safety and evacuation plan, fire safety and evacuation training for the facility, and fire safety and evacuation drills for the facility. Record review indicated that employees did not receive training twice per year after initial hire. During interview, LALD-D stated she misunderstood the requirement and believed that training was only required once per year after hire. This deficient condition was verified by LALD-D during the interview. TIME PERIOD FOR CORRECTION: Twenty-one	0 810		

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0 810	Continued From page 21 (21) days	0 810		
01060 SS=D	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and	01060		

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01060	Continued From page 22 (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation to the resident, legal representative, or designated representative, for one of two residents (R9) and failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) of the emergency relocation greater than four days, for one of two residents (R9). 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: R9 was admitted to the licensee on March 18, 2022, for assisted living services. The surveyor reviewed R9's Progress notes dated February 24, 2023, through April 12, 2023, which indicated R9 was transferred via ambulance to the hospital on February 24, 2023, for altered mental status and fever. R9 returned	01060		

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01060	Continued From page 23 to the licensee on April 12, 2023, to resume assisted living services. R9's record lacked evidence the licensee provided the resident or resident's representative a written emergency relocation notice. The record also lacked evidence to indicate the licensee provided the notification to the OOLTC of the emergency relocation greater than four days as required. On July 19, 2023, at 11:19 a.m., clinical nurse supervisor (CNS)-C stated, "80 percent sure I mailed to POA [power of attorney] but I did not make a copy to us." In addition, CNS-C stated the emergency relocation notice and contacting OOLTC was a new process for the licensee around the time R9 relocated to the hospital. The surveyor inquired if the licensee contacted OOTLC after R9 was relocated for greater than four days. CNS-C stated they were unaware if it was provided to OOLTC because they could not find documentation if it had been completed. The licensee's Resident Agreement Termination - Emergency Relocation dated August 2021 read, "In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: a) The reason for the relocation; b) The name and contact information for the location to which the resident has been relocated and any new service provider; c) Contact information for the Office of Ombudsman for Long-Term Care; d) If known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and e) A statement that, if the facility refuses to	01060		

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01060	Continued From page 24 provide housing or services after relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. 2) the notice required for emergency relocation will be delivered as soon as practicable to: a) the resident, legal representative, and designated representative; b) Resident's case manager if on waivered services; and c) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01540 SS=D	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, 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	01540		

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01540	Continued From page 25 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 ensure direct-care staff completed at least eight hours of initial dementia care training within 80 working hours of the employment start date for one of three employees (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) 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: The licensee had a current Assisted Living Facility with Dementia Care (ALFDC) license effective April 1, 2023, with an expiration date of March 31, 2024. ULP-B was hired April 10, 2023, to provide direct care services to the licensee's residents. On July 17, 2023, from 10:54 a.m. to 11:18 a.m., the surveyor observed ULP-B provide cares to one resident residing in the licensee's secured unit as well as perform miscellaneous tasks within the secured unit. ULP-B's orientation check list lacked signatures indicating the completion of trainings for two required trainings which were titled, Dementia	01540		

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01540	Continued From page 26 Training 4 Hours (Required for All Staff) and Additional Dementia Training 4 Hours (Required for Direct Care Staff and LALD). On July 17, 2023, at 1:50 p.m., the surveyor requested additional documentation from Licensed Assisted Living Director (LALD)-D regarding dementia care training for ULP-B. On July 18, 2023, at 12:55 p.pm., LALD-D responded by email stating "We do not have additional documentation of Dementia training for ULP-B." On July 19, 2023, at 11:15 a.m., Clinical Nurse Supervisor (CNS)-C stated ULP are required to complete facility provided dementia care training prior to 80 working hours. CNS-C stated that facility provided trainings covered all topics and requirements defined in current statutes. The licensee's Orientation and Training: Employee policy dated August 1, 2023, indicates that Direct-care employees will complete at least eight (8) hours of training on the required dementia care training topics within 80 working hours of the employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01540		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident	01620		

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01620	Continued From page 27 reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident assessment and reassessment, not to exceed 90 calendar days from the last date of the assessment for one of four residents (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).	01620		

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01620	Continued From page 28 The findings include: R4 R4 admitted to the licensee on July 18, 2019, under the licensee's former comprehensive license and began receiving assisted living services on August 1, 2021. R4's diagnoses included mild cognitive impairment, essential hypertension, diabetes mellitus with stage 2 chronic kidney disease, and generalized muscle weakness. R4's Service Plan Agreement signed April 7, 2023, indicated R4 received assistance with medication management, monitoring and assessment by RN, laundry, insulin administration, blood glucose checks, dressing cue, bathing, and grooming. R4's record included 90-day nursing assessments dated December 14, 2022, April 7, 2023, and July 11, 2023. The assessments completed on April 7, 2023, and July 11, 2023, were 24 and five days late. On July 19, 2023, at 11:29 a.m., clinical nurse supervisor (CNS)-C stated ongoing assessment should be completed every 90 days. The surveyor inquired why R4's ongoing assessments were conducted after 90 days. CNS-C stated they were unaware of the reason assessments were not completed by day 90 because they were not employed by licensee at the time the assessments were completed. When CNS-C was asked about assessments which was late when working for licensee, CNS-C stated the assessment was started in time however, it was completed and signed late.	01620		

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01620	Continued From page 29 The licensee's Assessment of Clients [resident]-Initial and Ongoing policy dated May 23, 2022, indicated "ongoing client reassessment and monitoring will be conducted as needed, based on changes in the needs of the client and not to exceed 90 calendar days from the client's last date of the uniform assessment". No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medication administration was documented accurately for one of nine residents (R10) who received medication management.	01760		

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01760	Continued From page 30 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: R10 R10 was admitted on September 8, 2022. R10's signed service plan dated December 5, 2022, indicated R10 received services including assistance with medication administration. R10's medication administration record (MAR) for July 1, 2023, through July 31, 2023, indicated R10 received lidocaine 4 percent (%) patch applied to back one time daily to be on for 12 hours and off for 12 hours. R10's patch application was scheduled for 8:00 a.m. on the MAR. On July 18, 2023, at 8:46 a.m., the surveyor observed unlicensed personnel (ULP)-N apply the lidocaine patch to R10's middle lower back. The lidocaine patch applied lacked notation of the date applied and initials of ULP-N acknowledging when and by whom the patch was applied. On July 19, 2023, at 11:10 a.m., clinical nurse supervisor CNS-C indicated they were uncertain if patches applied to residents by ULPs should include a date and initials of the ULP that applied the patch. CNS-C indicated they would look into the policy and get back to the surveyor.	01760		

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01760	Continued From page 31 The licensee's Medication Administration: Topical From Transdermal Patch policy revised August 1, 2021, indicated the person applying the patch would "place initials and date on paper tape and place over the new patch". No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
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 store prescription medication securely and permit only authorized personnel to have access for two of nine residents (R6, R10). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include:	01880		

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01880	Continued From page 32 R6 R6's diagnoses included dementia in other diseases classified elsewhere, unspecified injury of head, unspecified Alzheimer's disease, essential hypertension, and generalized muscle weakness. R6's Service Plan Agreement signed April 7, 2023, indicated R6 received assistance with medication management, monitoring and assessment by RN, laundry, insulin administration, blood glucose checks, dressing cue, bathing, and grooming. R6's Service Plan Agreement also indicated medications being managed by the facility will be securely locked with limited access to authorized personnel. Specific/specialized resident storage needs will be indicated in the medication management section of their assessment and entered into the medication administration record. Controlled substances will always be double locked. Medications will be kept in a medication cart and/or a secured area in the resident's apartment unless specialized storage needs apply in which case it will be indicated on the service plan and/or medication administration record. Overflow medications may be kept in a secured central storage area in the nursing office. On July 17, 2023, at 9:15 a.m., the surveyor observed the following unsecured medications on R6's bathroom counter: protect zinc oxide paste skin protectant, protectant zinc paste, and phytoplex silicone cream. R10 R10's diagnoses included osteoarthritis, coronary artery disease, mitral regurgitation, stage three chronic kidney disease, chronic diastolic heart	01880		

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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
01880	Continued From page 33 failure, atrial fibrillation, and history of falls. R10's Service Plan Agreement signed December 5, 2022, indicated R10 received assistance with medication administration, monitoring and assessment by RN, dressing, bathing, grooming, toileting, transfers, bed mobility, ambulation, application and removal of compression stockings, bed making, laundry, and escort to desired locations in the building. R10's Medication Management Assessment dated May 25, 2023, indicated R10 requires assistance with medications, R10 is not able to self-administer any medications, and medications are kept in a locked medication cart. On July 18, 2023, at 8:46 a.m., the surveyor observed on R10's kitchen counter the following unsecured medications: Moxifloxacin hydrochloride (hcl) ophthalmic solution. The prescription label on the box was dated February 25, 2023. It was prescribed to R10, and the instructions indicated instill one drop to affected eye(s) three times a day for seven days. On July 19, 2023, at 11:32 a.m., clinical nurse supervisor (CNS)-C stated all medications are supposed to be locked away in the cabinets and no medication should be left anywhere in the resident room. CNS-C further stated any extra medications should be kept in the nursing office. The licensee's Medication Management Services policy dated August 1, 2021, indicated based on the nursing assessment, the RN will develop an individualized medication management plan for each client receiving any type of medication management services. In addition, the policy indicated [licensee] will determine which	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30474	A. BUILDING: _____ B. WING _____	07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEEPHAVEN WOODS SENIOR LIVING	18025 MINNETONKA BOULEVARD DEEPHAVEN, MN 55391

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01880	Continued From page 34 medication management services our agency will offer, which may include: storing and securing medications. 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 time sensitive medications were dated when opened for two of nine residents (R4, R9). In addition, the licensee failed to ensure to discard expired medication for one of nine residents (R9). 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:	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30474	A. BUILDING: _____ B. WING _____	07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEEPHAVEN WOODS SENIOR LIVING	18025 MINNETONKA BOULEVARD DEEPHAVEN, MN 55391

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01890	Continued From page 35 TIME SENSITIVE MEDICATION On July 18, 2023, at 9:05 a.m., the surveyor observed the second-floor medication cart in the medication room area and observed R4's Novolog injection Flexpen 100 unit (u)/milliliter (ml) and basaglar injection pen 100 u/ml in use without a legible date opened label. On July 18, 2023, at 10:00 a.m., unlicensed personnel (ULP)-G stated when the insulin pens are opened, they are supposed to be dated. On April 19, 2023, at 11:49 a.m., clinical nurse supervisor (CNS)-C stated, the nurses are responsible to ensure before handing out insulin pens, they are dated with open date. The manufacturer's Highlights of Prescribing Information Novolog Flexpen dated December, 2012, directed Novolog Flexpen to be discarded 28 days after opening. Basaglar Kwikpen Instructions for Use by the manufacturer dated November 2022, indicated throw away the pen you are using after 28 days, even if it still has insulin left in it. EXPIRED AND UNDATED MEDICATION On July 18, 2023, at 9:15 a.m., the surveyor conducted a review of R9's medication storage area and observed the following expired medication; OcuSOFT eyelid scrub plus with instructions on the prescription label to gently cleanse lid with one wipe twice daily as needed, expiration date May 3, 2023. R9's provider orders, dated March 9, 2023, included OcuSOFT lid scrub plus- two times daily as needed- gently cleanse lid with one wipe twice daily as needed- indicated for irritation.	01890		

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	30474	A. BUILDING: _____ B. WING _____	07/19/2023

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DEEPHAVEN WOODS SENIOR LIVING	18025 MINNETONKA BOULEVARD DEEPHAVEN, MN 55391

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01890	Continued From page 36 On July 18, 2023, at 9:15 a.m., during the same review of R9's medication storage area the surveyor observed the following medication that was not dated when opened; erythromycin ophthalmic ointment- apply one fourth ribbon in both lower eyelids every night at bedtime. R9's provider orders, dated March 9, 2023, included erythromycin ointment 5 milligrams (mg)/ gram (gm)- at bedtime- apply one fourth inch ribbon in both lower eyelids every night at bedtime (pull down eyelids to make pocket) indicated for dry eyes. R9's service plan agreement, dated March 23, 2022, indicated R9 received services including medication administration. On July 19, 2023, at 11:10 a.m., CNS-C stated all medications should have an open date and expired medications should be disposed of. CNS-C stated an expectation of the ULPs is that they put a date on and initial any medication they open, and they would report an expired medication. In addition, CNS-C stated a nurse goes through the medication storage areas weekly looking for medications that are not labeled and expired medications and should dispose of expired medications at that time. The licensee's Storage of Medication and Key Security policy dated April 19, 2023, indicated until the medication is set up for immediate or later administration by a nurse, a legend drug must be kept in its original container bearing the original prescription label with legible information stating the prescription number, name of drug, strength and quantity of drug, and expiration date of time-dated drug.	01890		

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	30474	A. BUILDING: _____ B. WING _____	07/19/2023

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01890	Continued From page 37 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed ensure up-to-date written or electronically recorded orders were maintained for one of three residents (R3) receiving treatments. 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: R3 admitted for assisted living services on	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30474	A. BUILDING: _____ B. WING _____	07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01970	Continued From page 38 December 14, 2022. R3's diagnoses included hypertension, benign prostatic hyperplasia, type 2 diabetes mellitus (DM2), and end stage renal disease. R3's Service Plan Agreement with effective date of May 18, 2023, indicated R3 received assistance with blood glucose monitoring one time per day, housekeeping, laundry, insulin administration, medication administration, reminders to attend meals, monthly vital signs, redirection with wandering, set up for dressing, assistance with hearing aid placement, and bathing reminders. On July 18, 2023, at a.m. 7:36, the surveyor observed unlicensed personnel (ULP)-H perform blood glucose monitoring on R3. R3's Service Checkoff List dated July 1 through July 31, 2023, included blood glucose monitoring at 7:00 a.m., daily. R3's provider orders signed December 8, 2022, included blood sugar diagnostic strip test one to two times daily. R3's record lacked a provider order to clarify if blood glucose monitoring would occur one time per day or two times per day. On July 18, 2023, at 12:58 a.m., clinical nurse supervisor (CNS)-C stated treatment orders required provider orders. The surveyor requested to see an order for one time per day blood glucose monitoring for R3. On July 19, 2023, at 11:31 a.m., CNS-C stated they did not have an order for R3's blood glucose	01970		

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01970	Continued From page 39 monitoring to be completed one time per day. The surveyor inquired how they started blood glucose monitoring one time per day. CNS-C stated they were unaware of how they started one time per day blood glucose monitoring but believed family may have requested it. The licensee's Development of Individualized Treatment Management Plan dated August 1, 2021, read, "The RN [registered nurse] ensures that each client's [resident's] Individualized Treatment Management Plan is kept up-to-date and consistent with prescriber's orders and with the needs and preferences of the client [resident]." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		

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

Type: Full
Date: *07/18/23*
Time: 10:00:00
Report: 8041231204

Food and Beverage Establishment Inspection Report

Location:
Deephaven Woods Senior Living
18025 Minnetonka Boulevard
Deephaven, MN55391
Hennepin County, 27

Establishment Info:
ID #: 0037915
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9522882187
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.

3-500B Microbial Control: hot and cold holding

3-501.16A2 ***** Priority 1 *****

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

A FEW ITEMS ON THE TOP OF THE COOKLINE PREP COOLER MEASURED 43-44F. SEE TEMP. LOG. ADJUST/REPAIR UNIT AS NEEDED TO MAINTAIN TCS FOODS AT 41F OR BELOW.

Comply By: 07/18/23

6-300 Physical Facility Numbers and Capacities

6-301.11 ***** Priority 2 *****

MN Rule 4626.1440 Provide an adequate supply of hand soap at each handwashing sink or group of 2 adjacent handwashing sinks.

NO SOAP AT THE MEMORY CARE KITCHEN HAND SINK. SOAP PROVIDED DURING INSPECTION.

Comply By: 07/18/23

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

ESTABLISHMENT DOES NOT HAVE A CURRENT CERTIFIED FOOD PROTECTION MANAGER. EMPLOYEE IS SCHEDULED TO TAKE FOOD SAFETY CLASS THIS WEEK AND APPLY FOR STATE CFPM CERTIFICATE.

Comply By: 08/18/23

Type: Full
Date: *07/18/23*
Time: 10:00:00
Report: 8041231204
Deephaven Woods Senior Living

Food and Beverage Establishment Inspection Report

4-500 Equipment Maintenance and Operation

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

THE CONDENSER IN THE WALK-IN COOLER IS LEAKING. FACILITY HAS SCHEDULED REPAIR.

Comply By: 07/25/23

Surface and Equipment Sanitizers

Quaternary Ammonia: = 400 ppm at Degrees Fahrenheit
Location: 3 comp. sink
Violation Issued: No

Quaternary Ammonia: = 400 ppm at Degrees Fahrenheit
Location: sani bucket- cookline
Violation Issued: No

Utensil Surface Temp.: = at 164 Degrees Fahrenheit
Location: dish machine- main kitchen
Violation Issued: No

Utensil Surface Temp.: = at 163 Degrees Fahrenheit
Location: dish machine- memory care
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 43 Degrees Fahrenheit - Location: cookline prep cooler: sliced tomato
Violation Issued: Yes

Process/Item: Cold Holding
Temperature: 44 Degrees Fahrenheit - Location: cookline prep cooler: sliced ham
Violation Issued: Yes

Process/Item: Cold Holding
Temperature: 41 Degrees Fahrenheit - Location: cookline prep cooler:
Violation Issued: No

Process/Item: Cold Holding
Temperature: 41 Degrees Fahrenheit - Location: walk-in cooler: grilled peppers
Violation Issued: No

Process/Item: Cold Holding
Temperature: 37 Degrees Fahrenheit - Location: walk-in cooler: cut tomato
Violation Issued: No

Process/Item: Cold Holding
Temperature: 41 Degrees Fahrenheit - Location: memory care cooler: hard boiled egg
Violation Issued: No

Type: Full
Date: *07/18/23*
Time: 10:00:00
Report: 8041231204
Deephaven Woods Senior Living

Food and Beverage Establishment Inspection Report

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: front beverage reach-in cooler: milk
Violation Issued: No

Process/Item: Hot Holding
Temperature: 162 Degrees Fahrenheit - Location: soup well: tomato
Violation Issued: No

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

Inspection was completed with Abby Schultz, Andrew Hunt and Rob Moore. Ashley Crews was the lead Health Regulation Division Nurse Evaluator.

This establishment has a commercial kitchen on the main floor and a serving kitchen in memory care. There is a cafe area on the main floor that is not currently being used.

Discussed the following:
-Employee illness policy and logging requirements
-Reporting foodborne illness complaints to the health dept.
-Handwashing
-Glove-use and bare hand contact
-Proper food storage
-Thermometer calibration
-Date marking
-Vomit clean-up procedures
-Restrictions concerning serving a highly susceptible population

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 8041231204 of 07/18/23.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/__/____

Inspection report reviewed with person in charge and emailed.

Signed:_____
Andrew Hunt
Culinary Director

Signed: Sarah Conboy
Sarah Conboy
Public Health Sanitarian III
651-201-3984
sarah.conboy@state.mn.us