Electronically Delivered

January 6, 2025

Licensee
Totalcare Assisted Living Services LLC
8005 33rd Avenue North
Crystal, MN 55427

RE: Project Number(s) SL39911015

Dear Licensee:

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

The Minnesota Department of Health completed an initial survey on November 21, 2024, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

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.

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. The Department of Health documents state correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Home Care 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 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

Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the

correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

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

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

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39911	A. BUILDING: _____ B. WING _____	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOTALCARE ASSISTED LIVING SERVICES LL(	8005 33RD AVENUE NORTH CRYSTAL, MN 55427

(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 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: SL39911015-0 On November 18, 2024, through November 21, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were five residents receiving services under the provisional Assisted Living Facility 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 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.	
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness	0 680		

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0 680	Continued From page 1 (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to post an emergency preparedness (EP) plan prominently. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that	0 680		

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0 680	Continued From page 2 has affected or has the potential to affect a large portion or all of the residents). The findings include: On November 18, 2024, at 10:49 a.m., during a facility tour, the surveyor did not observe an EP plan posted prominently with all the required contents. On November 18, 2024, at 12:58 a.m., administrator/unlicensed personnel (A/ULP)-E stated they were not able to locate the EP plan; and stated licensed assisted living director (LALD)-C may have brought the EP plan home to work on updating the EP plan. On November 19, 2024, at 10:35 a.m., LALD-C stated they were aware of the statue and had been working on the EP plan to ensure it contained all the required content. On November 20, 2024, at 2:46 p.m., LALD-C stated the EP plan was located at their personal residence while on vacation from November 14, 2024, through November 19, 2024, as they had forgotten to bring the EP plan back to the facility prior to leaving for vacation. LALD-C stated the EP plan usually was in the office next to the kitchen on a shelve, which was visible to all staff. The licensee's Emergency Preparedness Plan - Appendix Z Compliance policy dated September 1, 2024, indicated the licensee would have in place an EP plan, that is in alignment with facility's requirement to also comply with CMS (Centers for Medicare and Medicaid Services) Appendix Z. No further information was provided.	0 680		

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0 680	Continued From page 3 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 790 SS=D	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 maintain accessibility the portable fire extinguishers. This deficient condition 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) 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: On November 20, 2024, from 10:30 a.m. to 11:15 a.m., the surveyor toured the facility with	0 790		

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0 790	Continued From page 4 admin-resident assistant (ULP)-E. The locked door for the mechanical room in the lower level had two signs indicating that there was a fire extinguisher inside. The surveyor confirmed that there is a non-required fire extinguisher located inside of the locked mechanical room. Portable fire extinguishers shall be in conspicuous locations and be readily accessible. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
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) staff 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) Staff 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	0 810		

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0 810	Continued From page 5 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 staff 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 record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training and 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) 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 November 20, 2024, admin resident assistant (ULP)-E provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, titled "Emergency	0 810		

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0 810	Continued From page 6 preparedness 1.17 Fire Safety handout", undated, failed to include the following: 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 provided FSEP was from a third-party provider and had not been updated to the specific facility. The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. On November 20, 2024, at 10:30 a.m., ULP-E stated they understood the areas of their policy that were incomplete and would work on bringing them into compliance. The policy reviewed was an unedited policy purchased from a third-party provider that was not specific to the facility. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01060 SS=F	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;	01060		

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01060	Continued From page 7 (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 (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, and designated representative for one of one resident (R2).	01060		

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01060	Continued From page 8 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: R2 was admitted to the licensee on October 8, 2024, with diagnoses that included diabetes. R2's service plan dated October 8, 2024, indicated R2 received services of medication administration and blood glucose monitoring. R2's progress notes dated November 12, 2024, at 8:29 p.m., indicated R2 had fallen and was taken to hospital via ambulance. R2's progress notes dated November 13, 2024, at 9:09 a.m., indicated paramedics had brought R2 to the facility at 12:45 a.m. R2's record lacked documentation R2, R2's legal representative, and R2's designated representative had received a written notice with all the required content for an emergency relocation. On November 20, 2024, at 12:49 p.m., licensed assisted living director (LALD)-C stated clinical nurse supervisor (CNS)-D had indicated to them an emergency relocation should be completed if the resident were to be gone for four days or more; and R2 had only been gone for two hours. LALD-C stated a written notice of the emergency	01060		

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01060	Continued From page 9 relocation was not provided as they misunderstood the statue. On November 21, 2024, at 3:30 p.m., during the exit conference, CNS-D stated they had never provided an emergency relocation written notice to a resident when they were sent to urgent care or an emergency room. CNS-D stated they had only provided this if the resident were to be admitted to another facility. The licensee's Discharge and Transfer of Residents policy dated August 1, 2021, indicated the facility would, as soon as possible, provide written notice in the event of an emergency relocation to the resident, the resident's legal representative, the resident's designated representative, and the residents case manager if the resident received home and community-based services. The policy failed to indicate the required content of a written emergency relocation notice. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01290 SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be	01290		

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01290	Continued From page 10 classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study was associated with the licensee's current assisted living health facility identification (HFID) number for four of ten unlicensed personnel ((ULP)-F, ULP-H, ULP-I, ULP-J), one of one administrator/unlicensed personnel (A/ULP)-E, and one of one registered nurse (RN)-G. 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: ULP-F ULP-F was hired on December 6, 2023. ULP-F's Background Study Clearance dated November 14, 2023, indicated ULP-F could provide direct contact services for a licensee but was associated to a different address of where the facility was located and a different HFID that was owned by the same licensee. ULP-F's	01290		

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01290	Continued From page 11 Background Study Clearance lacked an affiliation to the licensee's HFID 39911. ULP-H ULP-H was hired on November 7, 2023. ULP-H's Background Study Clearance dated October 24, 2023, indicated ULP-H could provide direct contact services for a licensee but was associated to a different address of where the facility was located and a different HFID that was owned by the same licensee. ULP-H's Background Study Clearance lacked an affiliation to the licensee's HFID 39911. ULP-I ULP-I was hired on January 19, 2024. ULP-I's Background Study Clearance dated January 17, 2024, indicated ULP-I could provide direct contact services for a licensee but was associated to a different address of where the facility was located and a different HFID that was owned by the same licensee. ULP-I's Background Study Clearance lacked an affiliation to the licensee's HFID 39911. ULP-J ULP-J was hired on July 12, 2021. ULP-J's Background Study Clearance dated August 20, 2024, indicated ULP-J could provide direct contact services for a licensee but was associated to a different address of where the facility was located and a different HFID that was owned by the same licensee. ULP-J's Background Study Clearance lacked an affiliation to the licensee's HFID 39911. A/ULP-E	01290		

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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
01290	Continued From page 12 A/ULP-E was hired on May 26, 2020. A/ULP-E's Background Study Clearance dated May 15, 2023, indicated A/ULP-E could provide direct contact services for a licensee but was associated to a different address of where the facility was located and a different HFID that was owned by the same licensee. A/ULP-E's Background Study Clearance lacked an affiliation to the licensee's HFID 39911. RN-G RN-G's hire date was not obtained from licensee. On November 18, 2024, at 1:27 p.m., administrator/unlicensed personnel (A/ULP)-E stated RN-G was a contract nurse that would be on-call for the licensee when the clinical nurse supervisor was not available. Minnesota Board of Nursing website accessed on November 22,2024, at 10:29 a.m., indicated RN-G's registered nurse license was issued on September 26, 2012. RN-G's Background Study Clearance dated July 26, 2024, indicated RN-G could provide direct contact services for a licensee but was associated to a different address of where the facility was located and a different HFID that was owned by the same licensee. RN-G's Background Study Clearance lacked an affiliation to the licensee's HFID 39911. On November 18, 2024, at 1:27 p.m., A/ULP-E stated not all employee backgrounds were affiliated to the licensee's HFID as the licensee recently became aware of this need following a survey at another facility owned by the licensee. A/ULP-E stated they did not pay close attention to	01290		

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	39911	A. BUILDING: _____ B. WING _____	11/21/2024

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TOTALCARE ASSISTED LIVING SERVICES LL(	8005 33RD AVENUE NORTH CRYSTAL, MN 55427

(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
01290	Continued From page 13 the affiliation to the HFID and had not completely corrected all the backgrounds for this facility. The licensee's Recruitment and Hiring policy dated August 1, 2021, indicated licensee would complete a Minnesota Department of Human Services (DHS) background study on all employees following the step-by-step procedure established by DHS. No further information provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
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 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	01620		

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	39911	A. BUILDING: _____ B. WING _____	11/21/2024

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01620	Continued From page 14 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 reassessment and monitoring were completed no more than fourteen calendar days after initiation of services; and ongoing resident reassessment and monitoring were completed as needed based on changes in the needs of the resident but not to exceed 90 calendar days from the last date of assessment for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 was admitted to the licensee on October 8, 2024, with diagnoses that included diabetes. R2's service plan dated October 8, 2024, indicated R2 received services of medication administration and blood glucose. R2's assessment dated October 23, 2024, was completed fifteen days after the initiation of services. The assessment was one day late. R2's progress notes dated November 12, 2024,	01620		

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01620	Continued From page 15 at 8:29 p.m., indicated R2 had fallen, had "a little cut on the left side of [R2's] head." The progress notes also indicated R2 was taken to hospital via ambulance and the nurse had been notified. R2's progress notes dated November 12, 2024, at 11:06 p.m. indicated the licensee was notified by a nurse in the emergency room (ER) that R2 had a cut that was sutured (surgically closed) and would be returning to the facility. R2's progress notes dated November 13, 2024, at 9:09 a.m., indicated paramedics had brought R2 home to the facility at 12:45 a.m. R2's After Visit Summary (AVS) dated November 12, 2024, indicated reason for hospital emergency department visit was due to a fall. The AVS indicated a new diagnosis of head injury and serum creatinine raised (abnormal kidney function) R2's progress notes dated November 15, 2024, at 3:31 p.m., indicated the registered nurse (RN) had visited R2. The note indicated R2 had no recent falls and no recent ER visits. R2's record lacked reassessment and monitoring following an emergency room visit due to a fall, laceration (cut) with sutures, and new diagnosis of head injury. On November 21, 2024, at 1:47 p.m., clinical nurse supervisor (CNS)-D stated R2 was not at the facility when the nurse attempted the 14-day assessment; and it was too late when R2 had returned to the facility, so they came back the next day to perform the assessment. On November 21, 2024, at 3:30 p.m., during the	01620		

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01620	Continued From page 16 exit conference, CNS-D stated R2 never had any lacerations with sutures that they were made aware of. Also, CNS-D stated they would expect a change of condition assessment to be completed following a new diagnosis of head injury (injury that results in trauma to the skull or brain). The licensee's Assessment and Reassessment policy dated August 1, 2021, indicated the registered nurse (RN) would provide a reassessment visit to update the evaluation of the resident and services no more than fourteen days after initiation of services; and ongoing resident monitoring would be conducted as needed based on changes in the needs of the resident. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) 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.	01760		

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01760	Continued From page 17 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered as prescribed for one of one resident (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3 was admitted to the licensee on December 28, 2023, with diagnoses that included traumatic brain injury, chronic pain, and dementia. R3's service plan dated January 3, 2024, indicated R3 received services of medication administration and behavior management. On November 19, 2024, at 8:30 a.m., the surveyor observed unlicensed personnel (ULP)-H open two lidocaine patches and applied one to R3's right knee and one to R3's right ankle. The surveyor did not observe ULP-H write the date, time, or initials on the patches at the time of administration. During the administration, ULP-H stated they did not see in the computer where to place [R3's] lidocaine patch but was told where to place the patches. R3's record lacked an order to indicate the	01760		

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01760	Continued From page 18 lidocaine patch was to be applied to the right ankle. On November 19, 2024, at 9:00 a.m., clinical nurse supervisor (CNS)-D stated [R3's] lidocaine patch order should have indicated the location of where to place the patch and they were not sure why [ULP-H] could not find the directions for this in the computer. The surveyor observed CNS-D reviewing the medication in the computer. CNS-D stated they would correct this, and the staff should be putting the date/time with their initials on the patch just prior to administration. CNS-D stated the staff should be putting the patches on both knees and suspected [R3] was telling the staff where to place the patches. CNS-D stated they planned to talk to [R3] and then follow up with [R3's] doctor to clarify the order. The licensee's Medication Administration policy dated August 1, 2021, indicated all staff with responsibility for medication administration would have access to information about the medication being administered that included instructions related to the medication and specific to the resident as appropriate. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access.	01880		

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01880	Continued From page 19 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to monitor refrigeration temperatures to ensure temperatures were maintained according to the manufacturer's instructions for four of four residents (R2, R4, R5, R6) with medications stored in the refrigerator. 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 November 20, 2024, at 11:48 a.m., the surveyor observed the locked medication refrigerator in the office next to the kitchen. Upon opening the refrigerator, the surveyor observed the temperature to be at 17° Fahrenheit (F). Administrator/unlicensed personnel (A/ULP)-E verified the temperature reading and stated the temperature may not be accurate. The surveyor observed the following medications being stored in the refrigerator: - R2's four unused pens of Lantus Solostar; - R4's unopened Invega Sustenna injection; - R5's three unopened bottles of latanoprost ophthalmic solution; - R6's five unused pens of lispro Kwikpen; and - R6's seven unused pens of Lantus Solostar. On November 20, 2024, at 12:15 p.m., the	01880		

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01880	Continued From page 20 surveyor observed A/ULP-E taking out the old thermometer and replacing it with a new thermometer in the locked medication refrigerator in the office near the kitchen. On November 20, 2024, at 1:27 p.m., the surveyor observed the temperature to be at 28° F in the locked medication refrigerator in the office near the kitchen. On November 20, 2024, at 3:28 p.m., the surveyor observed the temperature to be at 31° F in the locked medication refrigerator in the office near the kitchen. On November 21, 2024, at 2:15 p.m., clinical nurse supervisor (CNS)-D stated they were not made aware of the refrigerator temperatures. CNS-D stated they called pharmacy to further advise and moving forward they would correct this. The licensee's Storage/Control of Medications policy dated August 1, 2021, indicated all prescription drugs are securely locked in substantially constructed compartments according to the manufacturer's directions when the licensee is providing storage of medication outside of the residents private living space. The manufacturer's instructions for latanoprost ophthalmic solution revised July 2022, indicated to store unopened bottle in the refrigerator at 36° F to 46° F. The manufacturer's instructions for Insulin Lispro Kwik pen revised July 2023, indicated to store unused pens in the refrigerator at 36° F to 46° F and not to use if the pen had been frozen.	01880		

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01880	Continued From page 21 The manufacturer's instructions for Lantus Solostar pen revised November 2023, indicated to store unused pens in the refrigerator at 36° F to 46° F and not to use if the pen had been frozen. The manufacturer's instructions for Invega Sustenna injectable suspension revised September 2024, indicated to store at room temperature at 77° F; excursions between 59° and 86° F were permitted. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		

Minnesota Department of Health

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

Type: Full
Date: *11/18/24*
Time: 11:00:00
Report: 1051241178

Food and Beverage Establishment Inspection Report

Location:
Totalcare Assisted Living Serv
8005 33rd Ave N
Crystal, MN55427
Hennepin County, 27

Establishment Info:
ID #: 0043816
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #:
ID #:

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

No NEW orders were issued during this inspection.

Food and Equipment Temperatures

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

Process/Item: Upright Cooler
Temperature: 41 Degrees Fahrenheit - Location: SLICED AMERICAN CHEESE
Violation Issued: No

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

MET WITH NURSE EVALUATOR, RHAWNIE QUINEHAN.

DISCUSSED THE FOLLOWING WITH THE KTICHEN MANAGER, OPHELIA:

EMPLOYEE ILLNESS LOG
REPORTABLE ILLNESSES & SYMPTOMS
HANDWASHING & GLOVE USE
VOMIT CLEAN-UP PROCEDURE

THE KITCHEN HAS MDF WOODEN CABINETS, GRANITE COUNTERTOPS WITH HOLLOW BASES, VINYL TILE FLOOR TEXTURES, A HIGH TEMP DISHWASHER, AND ORANGE PEEL TEXTURE CEILINGS.

Type: Full
Date: *11/18/24*
Time: 11:00:00
Report: 1051241178
Totalcare Assisted Living Serv

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 1051241178 of 11/18/24.

Certified Food Protection Manager: Andrew K. Anyaogu

Certification Number: FM118379 Expires: 08/03/26

Inspection report reviewed with person in charge and emailed.

Signed: _____
Ophelia Yafondo

Signed: _____
Kai Yang
Public Health Sanitarian 1
St. Cloud
320 640-3532
Kai.Yang@state.mn.us