Electronically Delivered

December 18, 2023

Licensee
The Harbor At Peace Village
300 Faxon Road North
Norwood Young America, MN 55368

RE: Project Number(s) SL28522015

Dear Licensee:

On December 7, 2023, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the August 10, 2023, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

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

HHH

Electronically Delivered

November 6, 2023

Licensee
The Harbor at Peace Village
300 Faxon Road North
Norwood Young America, MN 55368

RE: Project Number(s) SL28522015

Dear Licensee:

On October 24, 2023, 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 August 10, 2023. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the October 27, 2023, survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on August 12, 2023, found not corrected at the time of the October 24, 2023, follow-up survey and/or subject to penalty assessment are as follows:

2310-Appropriate Care And Services-144g.91 Subd. 4 (a) - $3,000.00

The details of the violations noted at the time of this follow-up survey completed on October 24, 2023 (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 $3,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

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 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
HRD 3A, 3rd Floor
P.O. Box 64900
625 Robert Street North
St. Paul, MN 55155

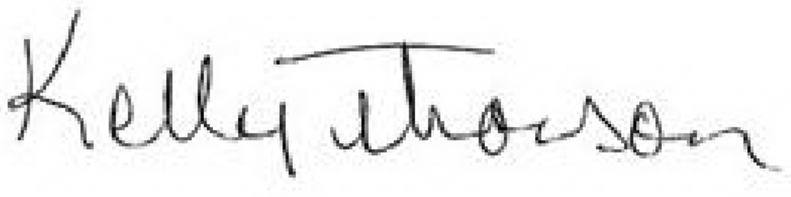
REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 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.

We urge you to review these orders carefully. If you have questions, please contact Kelly Thorson at 320-223-7336.

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,



Kelly Thorson, Supervisor
State Evaluation Team
Email: kelly.thorson@state.mn.us
Telephone: 320-223-7336 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28522	A. BUILDING: _____ B. WING _____	R 10/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HARBOR AT PEACE VILLAGE	300 FAXON ROAD NORTH NORWOOD YOUNG AMERIC, MN 55368

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: Project SL28522015-1 On October 24, 2023 through October 25, 2023, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on August 11, 2023. At the time of the survey, there were residents: 28 receiving services under the Assisted Living license. As a result of the revisit, the following orders were reissued. An immediate correction order was identified on October 24, 2023, issued for SL28522015-1, tag identification 2310. On October 25, 2023, the immediacy of correction order 2310 was removed, however, non-compliance remained at a level 3, scope of widespread violation.	{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.	

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{0 250}	Continued From page 1	{0 250}		
{0 250} SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department;	{0 250}		

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{0 250}	Continued From page 2 (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: No further action required	{0 250}		
{0 470} SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are	{0 470}		

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{0 470}	Continued From page 3 available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: No further action required	{0 470}		
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: No further action required	{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	{0 510}		

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{0 510}	Continued From page 4 national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: No further action required	{0 510}		
{0 580} SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: No further action required	{0 580}		
{0 640} SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and	{0 640}		

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{0 640}	Continued From page 5 suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: No further action required	{0 640}		
{0 650} SS=F	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and	{0 650}		

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{0 650}	Continued From page 6 (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: No further action required	{0 650}		
{0 660} SS=E	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: No further action required	{0 660}		
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies	{0 680}		

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{0 680}	Continued From page 7 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: No further action required	{0 680}		
{0 720} SS=F	144G.43 Subd. 2 Access to records The facility must ensure that the appropriate records are readily available to employees and contractors authorized to access the records. Resident records must be maintained in a manner that allows for timely access, printing, or transmission of the records. The records must be made readily available to the commissioner upon request. This MN Requirement is not met as evidenced by: No further action required	{0 720}		

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{0 730} SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and	{0 730}		

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{0 730}	Continued From page 9 any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: No further action required	{0 730}		
{0 900} SS=E	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative	{0 900}		

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{0 900}	Continued From page 10 according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: No further action required	{0 900}		
{0 920} SS=C	144G.50 Subd. 2 (c) Contract information (c) The contract must include: (1) a disclosure of the category of assisted living facility license held by the facility and, if the facility is not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license; (2) a description of all the terms and conditions of the contract, including a description of and any limitations to the housing or assisted living services to be provided for the contracted amount; (3) a delineation of the cost and nature of any other services to be provided for an additional fee; (4) a delineation and description of any additional fees the resident may be required to pay if the resident's condition changes during the term of the contract; (5) a delineation of the grounds under which the resident may be transferred or have housing or services terminated or be subject to an emergency relocation; (6) billing and payment procedures and requirements; and (7) disclosure of the facility's ability to provide specialized diets.	{0 920}		

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{0 920}	Continued From page 11 This MN Requirement is not met as evidenced by: No further action required	{0 920}		
{0 940} SS=C	144G.50 Subd. 2 (e; 5-7) Contract information (5) a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: (i) whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; (ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); (iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; (iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; (v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; (vi) a statement that residents may be eligible for assistance with rent through the housing support program; and (vii) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; (6) the contact information to obtain long-term	{0 940}		

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	28522	A. BUILDING: _____ B. WING _____	R 10/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HARBOR AT PEACE VILLAGE	300 FAXON ROAD NORTH NORWOOD YOUNG AMERIC, MN 55368

(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
{0 940}	Continued From page 12 care consulting services under section 256B.0911; and (7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: No further action required	{0 940}		
{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; (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	{01060}		

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{01060}	Continued From page 13 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: No further action required	{01060}		
{01500} SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such	{01500}		

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{01500}	Continued From page 14 as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by:	{01500}		

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{01500}	Continued From page 15 No further action required	{01500}		
{01610} SS=D	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan 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. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. This MN Requirement is not met as evidenced by: No further action required	{01610}		
{01620} SS=E	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	{01620}		

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{01620}	Continued From page 16 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: No further action required	{01620}		
{01650} SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the	{01650}		

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{01650}	Continued From page 17 facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: No further action required	{01650}		
{01790} SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if:	{01790}		

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{01790}	Continued From page 18 (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication.	{01790}		

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{01790}	Continued From page 19 This MN Requirement is not met as evidenced by: No further action required	{01790}		
{01820} SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: No further action required	{01820}		
{02110} SS=F	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic	{02110}		

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{02110}	Continued From page 20 medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: No further action required	{02110}		
{02170} SS=F	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the	{02170}		

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{02170}	Continued From page 21 resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced by: No further action required	{02170}		
{02310} SS=G	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the care and services were provided according to acceptable	{02310}		

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{02310}	Continued From page 22 health care and medical, or nursing standards for one of one resident (R9) whose consumer bed rail was removed without an assessment by the registered nurse (RN), and failed to assess one of one resident (R9) utilizing a security pole and curve grab bar. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: This resulted in an immediate correction order on October 24, 2023, at 4:50 p.m. The Stander Security Pole & Grab Bar undated assembly instructions noted "IMPORTANT: if installing the pole product next to the bed, couch, toilet, or any other object, Stander Inc. recommends NOT installing product closer than the user(s) ability to safely walk around the pole or there may be a possibility of becoming entrapped between the pole and the side of any object adjacent to the pole. Entrapment is a condition where an individual may become lodged between objects. The swivel handle must be taken into account when placing the pole next an adjacent object. In other words, the handle can rotate 360 degrees. The user(s) must be able to walk around the pole in every swivel handle position. It is the user(s) responsibility to ensure there is no possible way to become entrapped between the pole and/or pivoting handle and the	{02310}		

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{02310}	Continued From page 23 side of any object adjacent to the pole. Since there are a myriad of user conditions, installer/user(s) should determine if the pole should be installed farther away from the side of a bed." R9's diagnoses included diabetes type II, personal history of traumatic fracture, fracture of neck, neuropathy, high blood pressure, a history of falls, osteoarthritis, and pain in the right knee and left shoulder. R9's Service Plan dated February 6, 2023 indicated the resident received the following services: assistance with bathing, compression stockings, and medication administration. R9's AL Assessment dated July 20, 2023, identified as a 90 day assessment, noted the resident utilized a M rail to promote independence in bed mobility. It noted R9 required physical assist of one staff for transfers, was non ambulatory, and was independent with the wheelchair. R9's occupational therapy note dated August 30, 2023, noted diagnoses including muscle weakness, need for assistance with personal cares, reduced mobility, lack of coordination, repeated falling, and pain in the left shoulder. It also noted a falls risk and decreased cognition. R9 was educated on the benefits of utilizing the device. It noted transfer training would continue with staff. R9's Resident Incident Report dated September 15, 2023 at 8:15 a.m., noted R9 had a witnessed fall in her bedroom, reported she was moving too fast to the edge of her bed and slipped down to the floor. R9 denied pain and was assisted with	{02310}		

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{02310}	Continued From page 24 two staff and the mechanical left to get her off the floor. Contributing factors noted a fall history, impaired safety judgment, the use of assistive device, and being impulsive. Referred to therapy, and discussed with family about wearing cotton pajamas. On October 24, 2023, at 2:00 p.m., RN-A made a video call with the surveyor in R9's room. The bar was observed next to R9's bed on the right side, with approximately 2 inches between the bed and the pole device, and was observed to be affixed to the floor and the ceiling and unable to be moved when grasped by RN-A and attempted to move. RN-A stated she had not completed an assessment with R9 on the use of the bar, and had not assessed R9 prior to the M style rail being removed. RN-A stated therapy had been involved in selecting the device and ordering the device. RN-A stated R9 remained on every two hour safety checks with the use of the M style rail until it was removed immediately before the bar was installed. RN-A stated she had not reviewed the instructions for the device and was not aware of the message noted above to include the risk for entrapment. In addition, RN-A stated she was not aware of the need to do an assessment before the rail had been removed, or with the new device. On October 24, 2023, at 2:51 p.m., RN-A stated she was aware of the diagnoses included on the therapy note including repeated falls, weakness, reduces mobility, pain in the left shoulder, and decreased cognition. RN-A stated R9 has been falling, wearing silk pajamas, and slipping out of bed, which is why they involved therapy to see why she was falling and keep her safe. RN-A stated the last fall was on September 15, 2023, when R9 slid out of bed. RN-A stated she had	{02310}		

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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
{02310}	Continued From page 25 not received training and had not been involved in the training of staff on the use of the device. In addition, RN-A stated she had not checked the Consumer Product Safety Commission (CPSC) for a potential recall on the device. On October 24, 2023, at 3:15 p.m., maintenance supervisor (MS)-G stated he did the installation of the device for R9 next to her bed. MS-G stated he did not read the instructions completely, but skimmed over them. MS-G added he did not read the portion related to the risk for entrapment. On October 24, 2023, at 3:26 p.m., occupational therapist (OT)-J stated she selected the device, maintenance did the installation, and she trained R9 and staff on the use of the device, but was not sure if RN-A was in any of the training or not. OT-J stated she had some concern about this device sine the resident's bed moves so they were not able to maintain it to have walking distance around the device as instructed. OT-J stated when was aware of the risk for entrapment and did not relay this information to RN-A, but did use it in the training of staff to instruct them to keep the bed away from the device. OT-J stated she was aware the space between the bed and the pole was not meeting the requirement, and said it should be a priority to take this information to the RN. The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs), indicated "licensees should refer to individual manufacturer's guidelines for appropriate installation, maintenance and use. In addition, licensees should refer to the Consumer Product Safety Commission (CSPC) for the most up-to-date information related to portable bed	{02310}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28522	A. BUILDING: _____ B. WING _____	R 10/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HARBOR AT PEACE VILLAGE	300 FAXON ROAD NORTH NORWOOD YOUNG AMERIC, MN 55368

(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
{02310}	Continued From page 26 side rail recall information." No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	{02310}		
{02410} SS=D	144G.91 Subd. 13 Personal and treatment privacy (a) Residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a resident's space by knocking on the door and seeking consent before entering, except in an emergency or unless otherwise documented in the resident's service plan. (b) Residents have the right to have and use a lockable door to the resident's unit. The facility shall provide locks on the resident's unit. Only a staff member with a specific need to enter the unit shall have keys. This right may be restricted in certain circumstances if necessary for a resident's health and safety and documented in the resident's service plan. (c) Residents have the right to respect and privacy regarding the resident's service plan. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. This MN Requirement is not met as evidenced by: No further action required	{02410}		

Electronically Delivered

September 8, 2023

Licensee
The Harbor at Peace Village
300 Faxon Road North
Norwood Young America, MN 55368

RE: Project Number(s) SL28522015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 10, 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
St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,500.00**. 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

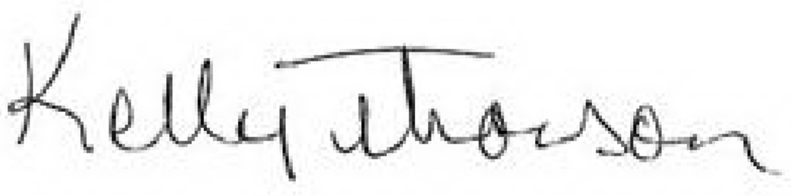
REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 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,



Kelly Thorson, Supervisor
State Evaluation Team
Email: kelly.thorson@state.mn.us
Telephone: 320-223-7336 Fax: 651-281-9796

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28522	A. BUILDING: _____ B. WING _____	08/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HARBOR AT PEACE VILLAGE	300 FAXON ROAD NORTH NORWOOD YOUNG AMERIC, MN 55368

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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: SL28522015-0 On August 7, 2023, through August 10, 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 68 residents, 58 of whom received services under the provider's Assisted Living with Dementia Care license. An immediate correction order was identified on August 9, 2023, issued for SL28522015-0, tag identification 2310. On August 11, 2023, the immediacy of correction order 2310 was removed, however, non-compliance remained at a level 3, scope of widespread violation.	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.	
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a	0 250		

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0 250	Continued From page 1 provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter;	0 250		

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0 250	Continued From page 2 (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required. 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 has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's "Application for Assisted Living License", section titled "Official Verification of	0 250		

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0 250	Continued From page 3 Owner or Authorized Agent", (page five of the application), identified "I certify I have read and understand the following:" [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45 (opens in a new window), my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17 (opens in a new window). - I have read and fully understand Minn. Stat. sect. 144G.80 (opens in a new window), 144G.81 (opens in a new window). and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22 (opens in a new window), my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G (opens in a new window). - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659 (proposed and not final) (opens in a new window). - Reporting of Maltreatment of Vulnerable Adults (opens in a new window). - Electronic Monitoring in Certain Facilities (opens in a new window)." - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data (opens in a new window), the Commissioner will use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets the requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information	0 250		

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0 250	Continued From page 4 submitted to the commissioner in the application may, in some circumstances, be disclosed to the appropriate state, federal or local agency, and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license. All data submitted are considered private until MDH issues a license. - I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G (opens in a new window), and Minnesota Rules, chapter 4659 (proposed and not final) (opens in a new window), governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. - I have examined this application and all attachments and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct and complete. I will notify MDH, in writing, of any changes to this information as required. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G (opens in new window). and Minn. Rules chapter 4659 (proposed and not final) (opens in new window),	0 250		

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0 250	Continued From page 5 in place upon licensure and to keep them current as applicable. Page 6 was electronically signed by the licensee on May 20, 2022. The licensee had an Assisted Living Dementia Care license, issued on August 1, 2022. The licensee failed to ensure the following policies and procedures were developed and/or implemented: - orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; - conducting initial and ongoing resident evaluations and assessments of the resident needs; - infection control; - orientation to and implementation of the assisted living bill of rights; - conducting appropriate screenings, or documentation of prior screenings, to show that staff were free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention of Standards; and - medication and treatment management. As a result of this survey, the following orders were issued under 0470, 0480, 0510, 0580, 0640, 0650, 0660, 0680, 0720, 0730, 0780, 0800, 0810, 0900, 0920, 0940, 1060, 1500, 1610, 1620, 1650, 1790, 1820, 2040, 2110, 2170, 2310, 2410 and 2240, indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with the Minnesota statutes, section 144G.08 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 250	Continued From page 6 (21) days	0 250		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the daily staffing schedule was posted at the beginning of each work shift in a central location in each building of the facility,	0 470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 470	Continued From page 7 potentially affecting 58 of the licensee's current residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On August 7, 2023, at 11:27 a.m., during a tour of the facility, the layout of the facility included a main assisted living building with three levels, identified as the The Harbor, with a long hallway that led to an attached building that included more assisted living apartments and a secured memory care unit, identified as The Haven. Both buildings had a main entrance with a common area. The surveyors did not observe a posted daily staffing schedule in a central location in the Harbor assisted living building. At 11:40 a.m., the surveyors observed a daily staffing schedule near the main entrance of the Haven building; however, the schedule was dated July 30, 2023. On August 10, 2023, at 11:53 a.m., licensed assisted living director (LALD)-B stated she was responsible for posting the daily staffing schedule each day; however, the licensee was in transition between management companies, and she did not have access to the electronic medical record to be able to print off the daily staffing schedule to post for residents, staff, and visitors. The licensee's 2.03 Staffing & Scheduling policy,	0 470		

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0 470	Continued From page 8 dated August 1, 2021, indicated the daily work schedule must be posted, after redacting direct-care staff members' resident assignments, at the beginning of each work shift, in a central location in each building of a facility or campus, accessible to staff, residents, volunteers, and the public. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 480		

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	28522	A. BUILDING: _____ B. WING _____	08/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HARBOR AT PEACE VILLAGE	300 FAXON ROAD NORTH NORWOOD YOUNG AMERIC, MN 55368

(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
0 480	Continued From page 9 The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated August 9, 2023, for the specific Minnesota Food Code deficiencies. 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 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 three of five employees (unlicensed personnel (ULP)-D, ULP-F, ULP-L, ULP-H). This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 510		

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0 510	Continued From page 10 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 August 7, 2023, at 10:56 a.m., the surveyor observed ULP-D bring supplies for insulin administration into R11's apartment. ULP-D donned (applied) gloves while in apartment without using hand sanitizer. ULP-D used an alcohol pad to cleanse planned injection site on R11's abdomen, then administered insulin injection, and discarded used needle in appropriate sharps container in R11's apartment cabinet under sink. ULP-D left R11's apartment with gloves still on, walked to medication cart in hallway, removed gloves, and threw them away in medication cart garbage, documented in computer, then performed hand hygiene. On August 8, 2023, at 3:18 p.m., the surveyor observed while ULP-F provided incontinence care for R2. R2 was sitting on the toilet in his apartment, with no shirt, and pants and brief around his ankles. ULP-F stated R2 had an "accident," and a strong stool smell was noted. ULP-F had gloves on and was using a washcloth to clean R2's lower back and asked R2 to sit forward while she cleaned his buttocks. ULP-F tossed the soiled washcloth into a plastic bag, removed the gloves and threw them into the trash. ULP-F performed hand hygiene with hand sanitizer and donned a new pair of gloves. ULP-F pushed the sit to stand lift up to R2, and R2 lifted his feet and placed his feet onto the platform. ULP-F assisted R2 to put on a clean shirt, and	0 510		

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0 510	Continued From page 11 placed the belt sling under R2's arms and buckled the clasps on his chest. ULP-F instructed R2 with hand placement and used the lift to raise R2's buttocks off of the toilet. While R2 was semi-standing, ULP-F again wiped R2's perineum, removed her gloves and threw them into the trash, and wiped her hands on her clothing. Without performing hand hygiene, ULP-F donned new gloves, used the lift to assist R2 to continue to stand, pulled up R2's brief and pants, and lowered R2 into the wheelchair. ULP-F removed her gloves and applied hand sanitizer. During an interview on August 8, 2023, at 3:33 p.m., ULP-F stated her hands were sweaty and she was in a hurry to put new gloves on. ULP-F stated she should have performed hand hygiene when she removed her gloves, and not wiped her hands on her clothing. On August 9, 2023, at 7:09 a.m., the surveyor observed ULP-L providing medication administration with R3 in his apartment. ULP-L donned gloves, wiped R3's right index finger with an alcohol wipe, poked the finger with a lancet, wiped it, and placed a sample of blood on the test strip. After completing, ULP-L wiped R3's abdomen with an alcohol wipe and administered 50 units insulin glargine in the left abdomen and 14 units Novolog insulin in the right abdomen and disposed of the needles in the sharps container on the counter. ULP-L then administered dorzolamide eye drops, one drop in each eye. At this time, ULP-L removed her gloves and donned clean gloves, administered the oladaterol inhaler and provided R3 with his oral medications. Upon completion of the tasks, ULP-L removed her gloves and performed hand hygiene. On August 9, 2023, at 7:28 a.m., ULP-L stated	0 510		

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0 510	Continued From page 12 she had been trained to remove her gloves and do hand hygiene after doing a blood glucose check but forgot to do it today. On August 10, 2023, at 12:10 p.m., registered nurse (RN)-A stated she would expect staff to change gloves and perform hand hygiene between procedures. On August 9, 2023, from approximately 7:57 a.m. to 8:30 a.m., during continuous observation, the surveyor observed ULP-H provide morning ADLs and administer medications for R9. Upon entering R9's room, the surveyor observed ULP-H, without completing hand hygiene or applying clean gloves assist R9 out of bed and then assisted R9 to the bathroom. Without completing hand hygiene or putting on clean gloves, ULP-H then removed R9's incontinence products. ULP-H then put on gloves without completing hand hygiene and assisted R9 with washing while on toilet. After completing washing, the surveyor observed ULP-H apply a medicated cream to R9's shoulder. After application of the medicated cream ULP-H was then observed washing their glove off in the sink to remove residual cream, then continued providing morning cares while wearing the same gloves. ULP-H then removed their gloves and without completing hand hygiene put on a clean pair of gloves to provide perineal cares to R9. The surveyor then observed ULP-H remove gloves while pulling up clean incontinence pad on R9. ULP-H reported that they needed to remove the gloves due to not being able to properly grip the incontinence product. Upon completion of morning cares, ULP-H was then observed completing hand hygiene at the bathroom sink. On August 10, 2023, at approximately 11:50 a.m., licensed practical nurse (LPN)-C stated ULPs	0 510		

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0 510	Continued From page 13 were trained to perform hand hygiene prior to providing cares, in between glove changes and after completing cares. LPN-C stated that gloves should not be rinsed off in sink. The licensees 8.01 Infection Control Policy dated August 1, 2021, indicated that the infection control program will be consistent with current guidelines from CDC for prevention control in long-term care facilities, where applicable in assisted living facilities. The licensee's 8.09 Hand Washing policy, dated August 1, 2021, directed, when conducting a procedure requiring the use of gloves, proper hand hygiene should be completed before donning gloves and after removing gloves. The Centers for Disease Control's (CDC), "CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings" dated November 29, 2022, under section 5a.1-2 reads: 1.) Require healthcare personnel to perform hand hygiene in accordance with Centers for Disease Control and Prevention (CDC) recommendations. 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	0 510		

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0 510	Continued From page 14 Under section 5d.1 reads: 1. Ensure proper selection and use of personal protective equipment (PPE) based on the nature of the patient interaction and potential for exposure to blood, body fluids and/or infectious material: a.) Wear gloves when it can be reasonably anticipated that contact with blood or other potentially infectious materials, mucous membranes, non-intact skin, potentially contaminated skin or contaminated equipment could occur. b.) Wear a gown that is appropriate to the task to protect skin and prevent soiling of clothing during procedures and activities that could cause contact with blood, body fluids, secretions, or excretions. c.) Use protective eyewear and a mask, or a face shield, to protect the mucous membranes of the eyes, nose and mouth during procedures and activities that could generate splashes or sprays of blood, body fluids, secretions and excretions. Select masks, goggles, face shields, and combinations of each according to the need anticipated by the task performed. d.) Remove and discard PPE, other than respirators, upon completing a task before leaving the patient's room or care area. If a respirator is used, it should be removed and discarded (or reprocessed if reusable) after leaving the patient room or care area and closing the door. e.) Do not use the same gown or pair of gloves for care of more than one patient. Remove and discard disposable gloves upon completion of a task or when soiled during the process of care. f.) Do not wash gloves for the purpose of reuse.	0 510		

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0 510	Continued From page 15 No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain documentation of quality management activity programs appropriate to the size and relevant to the type of services provided. This had the potential to affect all residents 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 a widespread scope (when problems are pervasive or represent a systemic	0 580		

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0 580	Continued From page 16 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On August 8, 2023, at 4:10 p.m., licensed assisted living director (LALD)-B stated everything on their computers had been wiped clean by the previous management company, including their quality management files. LALD-B stated they had been trending falls, medication errors, and other topics, but no documentation was available. The licensee's Quality Management Project policy dated August 1, 2021, noted the licensee would have at least one documented quality management project in place at all times and would retain records for at least two years. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 580		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and	0 640		

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0 640	Continued From page 17 (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment as required. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On August 7, 2023, at 11:27 a.m., during a tour of the facility, the surveyors did not observe the required 911 posting in common areas and near telephones provided by the assisted living facility. On August 10, 2023, at 11:57 a.m., licensed assisted living director (LALD)-B and licensed practical nurse (LPN)-C stated they were not aware of the 911 emergency number being posted in the facility. The licensee's 2.44 Vulnerable Adult Maltreatment - Prevention & Reporting policy, dated August 1, 2021, noted the licensee would post the 911 emergency number in common	0 640		

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0 640	Continued From page 18 areas and near telephones provided by the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640		
0 650 SS=F	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records	0 650		

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0 650	Continued From page 19 contained the required content for three of four employees (unlicensed personnel (ULP)-E and ULP-F, ULP-D). 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 August 31, 2020, under the licensee's former comprehensive license and started providing assisted living services August 1, 2021. ULP-E employee record lacked the following required content: - documentation of annual performance reviews that identify areas of improvement needed and training needs. ULP-F ULP-F was hired on March 19, 2019, under the licensee's former comprehensive license and started providing assisted living services August 1, 2021. Although ULP-F's employee record contained an Annual Development Discussion form, dated June 12, 2019, the record lacked the following required content: - documentation of annual performance reviews that identify areas of improvement needed and training needs.	0 650		

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0 650	Continued From page 20 ULP-D ULP-D was hired on February 18, 2020, under the licensee's former comprehensive license and started providing assisted living services August 1, 2021. Although ULP-D's employee record contained a Team Member Connections Form, dated July 20, 2021, the record lacked the following required content: - documentation of annual performance reviews that identify areas of improvement needed and training needs. On August 10, 2023, at 1:15 p.m., licensed assisted living director (LALD)-B stated each employee should have a performance review completed annually by their supervisor. Their annual performance review timing does not correlate with employee anniversary date or birthday, but a set month each year that all employee performance reviews are due. The licensee's 5.09 Employee Files policy dated August 1, 2021, indicated the licensee would keep an employee record for all paid employees. Employee records will be kept up-to-date and confidential and include the following: - Documentation of annual performance reviews that identify areas of improvement needed and training needs TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 660 SS=E	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a	0 660		

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0 660	Continued From page 21 comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included a completion of a two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test and a health history and symptom screening two of four employees, (registered nurse (RN)-A), unlicensed personnel (ULP)-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).	0 660		

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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
0 660	Continued From page 22 The findings include: RN-A and ULP-E's employee records lacked evidence of: - two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test; and - documentation of a completed health history and symptom screening. RN-A RN-A was hired on June 26, 2023, to provide direct care services to residents of the facility. Throughout the course of the survey, RN-A was observed in the nursing office right outside the main dining room in the Harbor building, which also had resident apartments, and interacting with residents in both buildings. ULP-E ULP-E was hired on August 31, 2020, under the licensee's former comprehensive license and started providing assisted living services August 1, 2021. On August 9, 2023, at approximately 11:00 a.m., licensed practical nurse (LPN)-C stated that all documentation related to TB testing should be stored in the employee file and if it is not in the file, then it is missing. On August 10, 2023, at approximately 1:45 p.m., licensed assisted living director (LALD)-B stated that TB tests should be completed per licensee policy. LALD-B again indicated that there was no record for a TB test being performed on ULP-E. The Minnesota Department of Health (MDH)	0 660		

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	28522	A. BUILDING: _____ B. WING _____	08/10/2023

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0 660	Continued From page 23 guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines, indicated an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record." The licensee's 8.16 Tuberculosis Screening policy dated August 1, 2021, indicated that staff whose essential job functions require work within the same air space of home care clients will be screened and tested for tuberculosis prior to the staff being exposed to clients. In addition, no staff will be permitted to begin work where the work involves sharing the air space with residents until the negative results of the first Mantoux are read and documented or a negative IGRA blood test result is received and documented, and staff TB screening results will be kept in each employee medical file. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses	0 680		

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0 680	Continued From page 24 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 interview and record review, the licensee failed to maintain a written emergency preparedness (EP) plan with all the required content as defined in Appendix Z. 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 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 680		

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0 680	Continued From page 25 The findings include: The licensee's emergency disaster preparedness plan lacked evidence of the following required content: - Annual review of the EPP; - Quarterly review of missing resident policy; - Policies and procedures for subsistence needs for staff and residents; - Policies and procedures for sheltering in place; - Policies and procedures for medical documents; - Roles under wavier declared by secretary; - Development of Communication Plan; - Emergency officials contact information; - Methods for sharing information; - long term care family notifications; and - emergency prep testing to include a disaster drill. On August 8, 2023, at 12:10 p.m., maintenance supervisor (MS)-G stated that they were unaware that the emergency preparedness plan needed to be updated annually and that missing resident plan require a quarterly update. In addition, MS-G stated the EPP was their responsibility, and they were not aware of all the items that needed to be included in the EPP. The licensee's Emergency Preparedness policy dated August 1, 2021, indicated the plan will be in writing and reviewed annually. In addition, the emergency preparedness plan will include policies and procedures designed to align with the LTC requirements in Appendix Z. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		

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0 720	Continued From page 26	0 720		
0 720 SS=F	144G.43 Subd. 2 Access to records The facility must ensure that the appropriate records are readily available to employees and contractors authorized to access the records. Resident records must be maintained in a manner that allows for timely access, printing, or transmission of the records. The records must be made readily available to the commissioner upon request. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the appropriate records for residents and staff were readily available for timely access to employee, vendors, and the commissioner authorized to access the records. 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: The licensee failed to ensure resident and employee records were readily accessible. August 7, 2023: - 7:58 a.m. and 8:00 a.m., the surveyor attempted to call the telephone number available to announce the survey. However, there was no answer and no voice mail, so the surveyor was	0 720		

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0 720	Continued From page 27 unable to leave a message. - 8:03 a.m., the surveyor sent an email to licensed assisted living director (LALD)-B, with information regarding the survey. - 10:00 a.m., upon entrance to the facility, LALD-B stated the licensee had changed management companies as of July 29, 2023, and the email addresses had changed, so she had not received the email from the surveyor. - 10:45 a.m., LALD-B stated she would have to reach out to the new management company for the policies and procedures, and stated staff at the facility did not have access to them yet and had not been trained on the new policies and procedures. - 10:50 a.m., during the entrance conference, LALD-B stated the human resources department from the previous management company had the electronic portion of the employee records, but they did have paper records on site. - 12:45 p.m., LALD-B stated vice president of clinical operations (VPCO)-K, from the management company, did not have access to the licensee's electronic resident records. - 1:15 p.m., the surveyor provided the current resident roster to LALD-B to be filled in completely, as they only had filled in the resident names, but no additional required information. - 1:55 p.m., LALD-B stated registered nurse (RN)-A was working on the current resident rosters. - 3:05 p.m., RN-A stated she was working on the	0 720		

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0 720	Continued From page 28 rosters, but she was new and had to go through each resident chart one by one to find the required information. RN-A said she could call corporate to help, but the on-call nurses don't even have access to the electronic records, and she was not sure if VPCO-K had access either. - 3:14 p.m., received one page of the current roster, and at 3:57 p.m., received two additional pages of the current roster. - 4:18 p.m., LALD-B stated she has been on hold with the electronic record company as she is unable to pull the current roster from the system, and stated RN-A was working on the roster. - 5:45 p.m., LALD-B provided another current resident roster that was not complete. LALD-B stated the electronic record company had not transferred the information from the old management company to the new management company. - 6:00 p.m., LALD-B provided the discharged resident roster, and stated licensed practical nurse (LPN)-C would be here tomorrow, and she had worked at the facility longer than RN-A, so would have a better knowledge of the residents. August 8, 2023: - 8:35 a.m., the surveyors provided LPN-C with the current and discharge rosters to double check the content. - 9:10 a.m., LPN-C stated staff have limited access to the electronic resident records since the change in the management company, and stated they could see medications, believed they could do an assessment and new entries, but could not view anything prior to the management	0 720		

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0 720	Continued From page 29 change. - 9:35 a.m., the surveyors gave a list of resident documents request to LPN-C. When asked about the current roster for services, LPN-C stated she was still not able to access the electronic records but would provide the paper records available. - 10:15 a.m., received the resident paper records from LPN-C. - 10:25 a.m., LALD-B stated they did not realize until the surveyors requested information, they did not have access to the electronic records prior to July 29, 2023, when they changed to the new management company. - 3:30 p.m., LALD-B stated the electronic record company was going to "escalate" the request to get them access to the records. August 9, 2023: - 7:43 a.m., LALD-B provided transcript education information on employees received from the previous management company. -7:48 a.m., LPN-C provided a complete assessment for R3 dated August 7, 2023, and a sheet dated July 18, 2023, titled AL (assisted living) Nursing Assessment for R3, which contained no information, only the date it had been completed. LPN-C stated they still were not able to view information prior to August 4, 2023. - 11:08 a.m., LALD-B found she now had access to the assessments, and they would be emailed to the surveyors in a secure file. The files were received at 11:15 a.m.	0 720		

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0 720	Continued From page 30 The licensee's Resident Record - Access & Storage policy dated August 1, 2021, noted electronic records would be in a secure database with only authorized staff having access, and the records would be readily available to employees and contractors authorized to access the records. It addition, it noted the resident records would be made available to the Minnesota Department of Health (MDH) as requested. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 720		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans;	0 730		

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0 730	Continued From page 31 (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record included a discharge summary with the required content for one of one discharged resident (R5). 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	0 730		

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0 730	Continued From page 32 situation has occurred only occasionally). The findings include: R5 was admitted to the facility on January 23, 2017, and discharged to another assisted living facility on July 13, 2023. R5's diagnoses included psychotic disorder. R5's record lacked documented evidence of a discharge summary to include: - a summary of the resident's stay including diagnoses, course of illnesses, allergies, treatments and therapies, and pertinent lab, radiology, and consultation results; and - a final summary of the resident's status from the latest assessment or review including baseline and current mental, behavioral, and functional status. On August 8, 2023, at 10:15 a.m., licensed practical nurse (LPN)-C stated she was not able to get into the electronic resident record to see a discharge summary for R5 had been completed. On August 9, 2023, once the facility had access to the electronic record, they were still unable to provide a discharge summary. The licensee's 2.38 Resident Record - Information and Content policy dated August 1, 2023, noted the resident record must include a discharge summary. No further information was provided. TIME PERIOD FOR CORRECTIONS: Twenty-one (21) days	0 730		

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0 780	Continued From page 33	0 780		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that are interconnected so that actuation of one alarm causes all alarms in the dwelling unit to actuate. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a	0 780		

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0 780	Continued From page 34 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: On facility tour with licensed assisted living director (LALD)-B on August 7, 2023, between approximately 2:30 p.m. and 5:00 p.m., it was observed that interconnected smoke alarms were not provided outside and in the immediate vicinity of sleeping rooms. This deficient condition was visually verified by LALD-B accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment,	0 800		

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0 800	Continued From page 35 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 all 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, 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: On facility tour with licensed assisted living director (LALD)-B on August 7, 2023, between approximately 2:30 p.m. and 5:00 p.m., it was observed that the doors to the laundry rooms were consistently propped open. These doors are required to close and latch. They must not be blocked in the "open" position as closing the door prevents fire from spreading in the event of an emergency. It was also observed that an exit stairwell had storage contained underneath the stairs. Combustible storage is not allowed in these areas so that a safe area of egress is maintained during an emergency. These deficient conditions were visually verified by LALD-B accompanying on the tour. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		

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

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	28522	A. BUILDING: _____ B. WING _____	08/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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0 810	Continued From page 37 licensee failed to develop a fire safety and evacuation plan with required elements and failed to conduct required evacuation drills. 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 August 7, 2023, at approximately 5:00 p.m. with licensed assisted living director (LALD)-B on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of the available documentation indicated that the fire safety and evacuation plan did not include 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. The facility plan did include some provisions for relocation of residents but did not specify how to move or evacuate residents or identify the unique and unusual needs of the residents. During interview, LALD-B verified that the fire safety and evacuation plan for the facility lacked these provisions. Record review of the available documentation	0 810		

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0 810	Continued From page 38 indicated that the licensee did not conduct evacuation drills twice per year per shift and every other month as required by statute. During interview, LALD-B stated that the facility had recently changed ownership and there were difficulties locating documentation. LALD-B stated that records for these drills were not available and verified this deficient condition. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 900 SS=E	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative	0 900		

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0 900	Continued From page 39 according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract prior to providing assisted living services for two of four residents (R3, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R3 R3 began receiving services under the assisted living licensure on June 23, 2023. R3's Service Plan dated effective July 19, 2023, noted services including assistance with bathing, dressing, grooming, and medication administration. R3's record contained a contract dated effective June 23, 2023. The contract was signed by the licensee on June 28, 2023 (five days after admission to the facility). In addition, the contract	0 900		

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0 900	Continued From page 40 lacked a signature by the resident documenting agreement. On August 10, 2023, at 12:20 p.m., licensed assisted living director (LALD)-B stated the contract should be signed by the resident or their legal representative. R4 R4 began receiving services under the assisted living licensure on August 1, 2021. However, R4's record lacked evidence of an updated signed contract. R4's Service Plan Agreement dated April 7, 2023, included medication administration and assistance with activities of daily living. R4's Housing with Services agreement was signed July 23, 2016. On August 9, 2023, at 10:37 a.m., LALD-B verified that the contract for R4 was put into effect prior to August 1, 2021. LALD-B stated that the provided copy of R4's signed contract was the most up to date copy that they were able to locate. LALD-B stated that they believed that there had been an updated contract signed but was unable to locate this updated contract during the survey process. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 900		
0 920 SS=C	144G.50 Subd. 2 (c) Contract information (c) The contract must include:	0 920		

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0 920	Continued From page 41 (1) a disclosure of the category of assisted living facility license held by the facility and, if the facility is not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license; (2) a description of all the terms and conditions of the contract, including a description of and any limitations to the housing or assisted living services to be provided for the contracted amount; (3) a delineation of the cost and nature of any other services to be provided for an additional fee; (4) a delineation and description of any additional fees the resident may be required to pay if the resident's condition changes during the term of the contract; (5) a delineation of the grounds under which the resident may be transferred or have housing or services terminated or be subject to an emergency relocation; (6) billing and payment procedures and requirements; and (7) disclosure of the facility's ability to provide specialized diets. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written assisted living contract with the required content for three of three residents (R1, R2, R3). 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	0 920		

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0 920	Continued From page 42 the residents). The findings include: R1 R1's record contained a Resident Contract, dated January 1, 2023, and signed by R1's husband on January 14, 2023. R2 R2's record contained a Resident Contract, dated January 1, 2023, and signed by R2's daughter on January 16, 2023. R3 R3's contained an unsigned Resident Contract, dated June 23, 2023. R1, R2, and R3's record lacked a written contract to include: - a disclosure of the category of assisted living facility license held by the facility and, if the facility is not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license. On August 10, 2023, at 12:05 p.m., licensed assisted living director (LALD)-B stated the residents' current contracts were utilized when the previous management company was involved, so they would be receiving new contracts with the transition to a new management company. LALD-B stated the contract should include the required content. The licensee's 1.05 Signing an Assisted Living Contract policy, dated August 1, 2021, indicated a signed Assisted Living contract must be signed and received by the facility when a prospective resident decided to move in; however, the policy did not address the required contents of the contract.	0 920		

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0 920	Continued From page 43 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 920		
0 940 SS=C	144G.50 Subd. 2 (e; 5-7) Contract information (5) a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: (i) whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; (ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); (iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; (iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; (v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; (vi) a statement that residents may be eligible for assistance with rent through the housing support program; and (vii) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program;	0 940		

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0 940	Continued From page 44 (6) the contact information to obtain long-term care consulting services under section 256B.0911; and (7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for three of three residents (R1, R2, R3). 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: R1 R1's record contained a Resident Contract, dated January 1, 2023, and signed by R1's husband on January 14, 2023. R2 R2's record contained a Resident Contract, dated January 1, 2023, and signed by R2's daughter on January 16, 2023. R3 R3's contained an unsigned Resident Contract, dated June 23, 2023. R1, R2 and R3's records lacked a written contract to include:	0 940		

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0 940	Continued From page 45 - whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; - whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); - whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; - whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; - a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; - a statement that residents may be eligible for assistance with rent through the housing support program; and - a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program. On August 10, 2023, at 12:05 p.m., licensed assisted living director (LALD)-B stated the residents' current contracts were utilized when the previous management company was involved, so they would be receiving new contracts with the transition to a new management company. LALD-B stated the contract should include the required content. The licensee's 1.05 Signing an Assisted Living Contract policy, dated August 1, 2021, indicated a signed Assisted Living contract must be signed	0 940		

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0 940	Continued From page 46 and received by the facility when a prospective resident decided to move in; however, the policy did not address the required contents of the contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 940		
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; (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.	01060		

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01060	Continued From page 47 (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 required content for an emergency relocation for two of two residents (R1, R10). Additionally, the licensee failed to notify the Office of Ombudsman for Long-Term Care (OOLTC) of the emergency relocation for one of one resident (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, 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: R1 R1 was admitted for services under the comprehensive home care license on April 22,	01060		

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01060	Continued From page 48 2020, and began receiving assisted living services on August 1, 2021. R1's Service Plan signed July 14, 2023, indicated R1 received assistance with transfers, ambulation, bathing, dressing, grooming, toileting, oral care, nail care, dining set up, medication management, nebulizer, housekeeping, laundry, trash removal, escort to meals and activities. R1's Progress Note entered on July 6, 2023, at 8:32 a.m., by registered nurse (RN)-A, indicated R1 was being sent to hospital emergency room for evaluation and treatment of left side pain. R1's Progress Note entered on July 8, 2023, at 2:25 p.m., by RN-M, indicated R1 had been admitted to the hospital from July 6, 2023, to July 8, 2023. R1 returned to licensee's facility at 12:34 p.m. on July 8, 2023. R1's record lacked a written notice delivered to the resident or designated representative that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for OOLTC; - 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 - 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.	01060		

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01060	Continued From page 49 R10 R10 was admitted for services under the comprehensive home care license on December 9, 2019, and began receiving assisted living services on August 1, 2021. R10's Service Plan signed June 20, 2023, indicated R10 received assistance with bathing, dressing, grooming, oral care, nail care, medication management, daily weight, daily blood pressure monitoring, fasting blood glucose monitoring, insulin administration, housekeeping, laundry, trash removal, and safety checks. R10's Hospital Discharge Summary, dated August 24, 2022, indicated R10 was admitted to the hospital on August 15, 2022, and discharged to licensee on August 24, 2022. R10's record lacked a written notice delivered to the resident or designated representative that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for OOLTC; - 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 - 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. In addition, R10's record lacked notification to OOLTC when R10 did not return to the facility	01060		

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01060	Continued From page 50 within four days. On August 9, 2023, at 11:35 a.m., licensed assisted living director, (LALD)- B stated when residents are hospitalized, they are put on leave of absence in their computer system and family is notified. LALD-B was not aware of the required written notification of emergency relocation or the requirement of notification to OOLTC if the resident did not return to the facility within four days. On August 10, 2023, at 12:45 p.m., registered nurse (RN)-A and licensed practical nurse (LPN)-C stated they were also not aware of the required written notification of emergency relocation or the requirement of notification to OOLTC if the resident did not return to the facility within four days. On August 10, 2023, at 12:45 p.m., LALD-B, RN-A, and LPN-C agreed licensee had not completed written notification of emergency relocation or notification to OOLTC for any hospitalized residents. The licensee's 16.06 Emergency Relocation Requirements - Notify Ombudsman policy, dated December 14, 2022, indicated in the event of an emergency relocation, the facility would provide a written notice containing: -reason for the relocation; -name and contact information for the location to which the resident has been relocated; -contact information for the OOLTC; -the approximate date or range of dates within which the resident is expected to return, or a statement that a return date is not currently known; and -a statement that, if the facility refuses to provide	01060		

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	28522	A. BUILDING: _____ B. WING _____	08/10/2023

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01060	Continued From page 51 housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility will provide contact information for the agency to which the resident may submit an appeal. The policy indicated the notice must be delivered as soon as practicable to the: -resident; -resident's legal representative; -resident's designated representative; and -resident's case manager. In addition, if the resident has not return to the facility within four days the same notice will be sent to OOLTC. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing	01500		

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01500	Continued From page 52 techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication	01500		

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01500	Continued From page 53 access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure annual training including all required topics for each twelve months of employment for three of three employees (unlicensed personnel (ULP)-D, ULP-E, ULP-F). 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-D ULP-D was hired on February 18, 2020, under the licensee's former comprehensive license and started providing assisted living services August 1, 2021. ULP-D's employee record lacked the following required content: - review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures. On August 10, 2023, at 1:15 p.m., licensed assisted living director (LALD)-B stated each employee should complete annual training in Relias (computer module-based learning system). LALD-B stated licensee has a list of	01500		

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01500	Continued From page 54 modules from corporate office that everyone is to be assigned. Those modules are all included in assigning annual training to employees. ULP-E ULP-E was hired on August 31, 2020, under the licensee's former comprehensive license and started providing assisted living services August 1, 2021. ULP-E'S employee record lacked the following required content: - review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures. ULP-F ULP-F had a start date of March 19, 2019, and began providing assisted living services on August 1, 2021. ULP-F employee record lacked the following required content: - review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures. On August 10, 2023, at 10:00 a.m., LPN-C stated that all trainings were completed on Relias and that all documentation pertaining to Relias based trainings should be accurate and up to date, however, could not verify that employees had received a review of licensee's policies and procedures. The licensee's 5.06 Annual Required Staff Training policy dated August 1, 2021, indicated that employees performing direct care services would review the facility's policies and procedures	01500		

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01500	Continued From page 55 relating to the provision of assisted living services and how to implement those policies and procedures every 12 months. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		
01610 SS=D	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan 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. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed an initial, comprehensive nursing assessment prior to signing the assisted living contract/providing services for one of four residents (R3).	01610		

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01610	Continued From page 56 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: During the entrance conference on August 7, 2023, at 10:50 a.m., licensed assisted living director (LALD)-B stated the nurses completed a preadmission brief assessment, an admission assessment, 14-day reassessment, every 90-day reassessment, and with a change in condition for residents. R3's record lacked evidence the RN completed a nursing assessment of the physical and cognitive needs of the resident prior to the date on which the resident executed a contract with the licensee or the date on which the resident moved in, whichever was earlier. R3 admitted on June 23, 2023, with diagnoses including chronic kidney disease, arthritis in the knees, neuropathy in the hands and bilateral legs and feet. R3's Service Plan dated July 19, 2023, indicated R3 received services including: bathing, dressing, grooming, blood glucose testing, safety checks, and medication administration. R3's AL (Assisted Living) Nursing Assessment dated June 23, 2023, identified as the initial	01610		

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01610	Continued From page 57 assessment, had a date signed by a previously employed RN on June 28, 2023, five days after admission and receiving services. On August 10, 2023, at 12:20 p.m., LALD-B and RN-A stated the assessment is expected to be completed the same date as admission to the facility. The licensee's 6.01 Assessments, Reviews & Monitoring policy dated August 1, 2021, noted the licensee would conduct a nursing assessment prior to the date on which a prospective resident executed a contract with the facility or the date on when a prospective resident moved in, whichever was earlier. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01610		
01620 SS=E	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	01620		

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01620	Continued From page 58 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 monitoring and reassessments (initial, 14-day and 90-day) to include all areas required on the uniform assessment tool for three of four residents (R1, R3, R4) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During the entrance conference on August 7, 2023, at 10:50 a.m., licensed assisted living director (LALD)-B stated the nurses completed a preadmission brief assessment, an admission assessment, 14-day reassessment, every 90-day reassessment, and with a change in condition for	01620		

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01620	Continued From page 59 residents. R1 R1 was admitted on April 22, 2020, with diagnoses including dementia, hyperlipidemia, neuropathy, insomnia, osteoarthritis, and osteoporosis. R1's Service Plan dated July 14, 2023, indicated R1 received assistance with transfers, ambulation, bathing, dressing, grooming, toileting, oral care, nail care, dining set up, medication management, nebulizer, housekeeping, laundry, trash removal, escort to meals and activities. R1 was hospitalized beginning July 6, 2023, and returned to licensee on July 8, 2023. R1's record contained an AL (Assisted Living) Nursing Assessment dated July 14, 2023. The indications noted for this assessment were 90-day assessment and change of condition related to readmission. This change of condition assessment was completed seven days after R1 returned from hospitalization. On August 10, 2023, at 12:55 p.m., registered nurse (RN)-A, indicated the change of condition assessment should be completed right away when a resident returned from the hospital, within the first day the resident is back in the facility. R3 R3 admitted on June 23, 2023, with diagnoses including chronic kidney disease, arthritis in the knees, neuropathy in the hands and bilateral legs and feet. R3's Service Plan dated July 19, 2023, indicated R3 received services including: bathing, dressing, grooming, blood glucose testing, safety	01620		

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01620	Continued From page 60 checks, and medication administration. R3's record contained an AL (Assisted Living) Nursing Assessment dated June 23, 2023. R3's record also contained an AL Nursing Assessment identified as the 14-day assessment, dated July 18, 2023, 25 days after admission to the facility. On August 10, 2023, at 12:20 p.m., LALD-B and RN-A stated the assessment is expected to be completed within 14 days of admission. R4 R4 was admitted on July 2, 2019. R4's signed service plan dated April 7, 2023, included medication management, toileting assistance, and ongoing monitoring by a registered nurse not to exceed 90 calendar days from the date of the last review. R4's most recent comprehensive assisted living assessments were completed on March 24, 2023, and July 6, 2023. This resulted in 104 days elapsed between assessment dates. R4's record contained no additional assessments. During the entrance conference on August 7, 2023, at 10:15 a.m., LALD-B stated assessments should take place preadmission, at time of admission, followed by a 14-day assessment and then ongoing assessments not to exceed 90 days. The licensee's 6.01 Assessments, Reviews & Monitoring policy dated August 1, 2021, stated 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	01620		

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01620	Continued From page 61 as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01620		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those	01650		

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01650	Continued From page 62 chapters. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan included the required content for four of five residents (R1, R3, R4, 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 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: R1 R1's diagnoses included dementia, hyperlipidemia, neuropathy, insomnia, osteoarthritis, and osteoporosis. R1's Service Plan dated July 14, 2023, indicated R1 received assistance with transfers, ambulation, bathing, dressing, grooming, toileting, oral care, nail care, dining set up, medication management, nebulizer, housekeeping, laundry, trash removal, escort to meals and activities. However, it lacked information identifying who had the authority to sign for the resident in an emergency. R3 R3's diagnoses included chronic kidney disease, arthritis in the knees, neuropathy in the hands and bilateral legs and feet.	01650		

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01650	Continued From page 63 R3's Service Plan dated July 19, 2023, indicated R3 received services including bathing, dressing, grooming, blood glucose testing, safety checks, and medication administration. However, it lacked information identifying who had the authority to sign for the resident in an emergency. On August 10, 2023, at 12:20 p.m., licensed assisted living director (LALD)-B stated the required content was not included on the service plan, and thought this may be an issue with the electronic record system. R4 R4's diagnoses included osteoarthritis. R4's signed Service Plan dated April 7, 2023, indicated R4 received assistance with activities of daily living, medication administration, bathing, housekeeping and laundry assistance. However, it lacked information identifying who had the authority to sign for the resident in an emergency. R9 R9's diagnoses included type 2 diabetes. R9's signed Service Plan dated March 6, 2023, indicated that R9 received assistance with activities of daily living, medication administration, bathing, housekeeping and laundry assistance. However, it lacked information identifying who had the authority to sign for the resident in an emergency. The licensee's 6.08 Service plan policy date August 1, 2021, indicated that all service plan will contain the following: - A description of the services that are to be provided based on the most recent assessment and resident preferences;	01650		

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01650	Continued From page 64 - Fees for services to be provided; - The frequency of each service to be provided based on the most recent assessment and resident preferences; - An identification of staff or categories of staff who will be providing services (RN, LPN, unlicensed personnel, etc.); - A schedule and method for the next planned assessment or monitoring; - A schedule and method for the next planned monitoring of staff providing services; and - A contingency plan that includes: o Actions Cornerstone Management Services will take if scheduled services cannot be provided; o Information regarding how the resident can contact Cornerstone Management Services; o The names and contact information the resident wishes, if any, to have notified in an emergency or if there is a significant adverse change in the resident's condition; o Identification and contact information of who the resident has authorized, if any, to sign for the resident in an emergency; and o How the facility will support documented resident health care directive decisions, if any - including circumstances when emergency medical services are not to be summoned. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed	01790		

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01790	Continued From page 65 nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of	01790		

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01790	Continued From page 66 medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) developed comprehensive written procedures for the unlicensed personnel (ULP) providing medications for residents having unplanned time away when the licensed nurse was not available. 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: During the entrance conference on August 7,	01790		

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01790	Continued From page 67 2023, at approximately 10:50 a.m., licensed assisted living director (LALD)-B stated the licensee provided medication management services to the licensee's residents. The licensee's 7.01 Medication Management - Planned & Unplanned Time Away policy, dated August 1, 2021, indicated for unplanned time away when a pharmacist or licensed nurse were not available, the RN had trained the ULP and determined the ULP were competent to follow the procedures for giving medications to residents. The policy further indicated the RN had developed written procedures for the ULP, including any special instructions or procedures regarding controlled substances that were prescribed for the resident. On August 10, 2023, at 11:54 a.m., licensed practical nurse (LPN)-C and RN-A stated they were not aware of written procedures for the ULP, for giving medications to residents for unplanned time away, as required. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by:	01820		

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01820	Continued From page 68 Based on interview and record review, the licensee failed to ensure written or electronically recorded prescriptions were obtained for one of four residents (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: During the entrance conference on August 7, 2023, at 10:50 a.m., licensed assisted living director (LALD)-B stated the licensee provided medication management services to their residents. R3's diagnoses included chronic kidney disease, arthritis in the knees, neuropathy in the hands and bilateral legs and feet. R3's Service Plan dated July 19, 2023, indicated R3 received services including: bathing, dressing, grooming, blood glucose testing, safety checks, and medication administration. R3's prescriber orders dated August 3, 2023, included a blood thinner, insulin, and antihypertensives, but lacked an order for dorzolamide (to treat increased eye pressure). On August 10, 2023, at 12:20 p.m., licensed practical nurse (LPN)-C stated the order was on the admission orders, but got missed on the	01820		

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01820	Continued From page 69 current list of signed orders. The licensee's 7.20 Medication & Treatment Orders policy dated August 1, 2021, noted the registered nurse was responsible for assuring a current, authorized prescriber order for medications administered by the staff was kept on file in the residents' records. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide hazard vulnerability assessment or safety risk assessment of the physical environment on and around the property for the facility. This deficient practice had the ability to affect all staff, residents, and visitors.	02040		

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02040	Continued From page 70 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 August 7, 2023, at approximately 5:00 p.m. with licensed assisted living director (LALD)-B on the hazard vulnerability assessment for the physical environment of the facility. Record review of the available documentation indicated that the licensee had not performed a hazard vulnerability assessment with mitigation factors on and around the property. During interview, LALD-B stated the facility had conducted this assessment on the broader scale but verified that the licensee was not able to provide a hazard vulnerability assessment with mitigation factors for the physical environment on and around the property. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	02040		
02110 SS=F	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the:	02110		

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02110	Continued From page 71 (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, licensee failed to ensure policies and procedures required in the licensing of assisted living facilities with dementia care were provided to each resident and/or the residents legal/designated representative at the time of move-in. This had	02110		

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02110	Continued From page 72 the potential to affect all residents with dementia care. 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 has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee lacked evidence the required policies and procedures related to dementia care were provided to each resident and/or the resident's legal and designated representative. The licensee held an assisted living with dementia care license through August 31, 2023, and was licensed for a bed capacity of 82 residents. On August 7, 2023, at 12:07 p.m., licensed assisted living director (LALD)-B provided the required policies and procedures to the evaluators; however, indicated no evidence was found to verify the inclusive list of dementia care policies and procedures had been provided to each resident and/or representative. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02110		

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02170	Continued From page 73	02170		
02170 SS=F	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities.	02170		

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02170	Continued From page 74 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to conduct an evaluation for activities that addressed all provisions and failed to develop an individualized activity plan based on the evaluation, for two of two residents (R1, R2) who resided in the Haven secured memory care unit. 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 had an assisted living with dementia care license, effective August 1, 2022. R1 R1's diagnoses included dementia, hyperlipidemia, neuropathy, insomnia, osteoporosis, and osteoarthritis. R1's Service Plan signed July 14, 2023, indicated R1 received assistance with transfers, ambulation, bathing, dressing, grooming, toileting, oral care, nail care, dining set up, medication management, nebulizer, housekeeping, laundry, trash removal, escort to meals and activities. On August 8, 2023, at 3:05 p.m., the surveyor observed R1 at the dining room table with several other residents, coloring pictures from paper coloring books.	02170		

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02170	Continued From page 75 On August 10, 2023, at 2:30 p.m., the surveyor observed R1 in the day room with several other residents, R1 performed exercises with a plastic ball, then tossed the plastic ball into a basket, and participated in a beanbag toss game. On August 10, 2023, at approximately 1:50 p.m., LEC-N provided R1's AL (assisted living) Life Enrichment Assessment, dated May 4, 2023, identified as the annual evaluation. The assessment indicated R1 enjoyed a large variety of activities including gardening, puzzles, board games, reading books, sewing, knitting, crocheting, painting, bible study, and bird watching. R1's AL Life Enrichment Assessment lacked the following: - current abilities and skills; - physical abilities and limitations; and - adaptations necessary for the resident to participate. In addition, R1's record lacked an individualized activity plan based on the activity evaluation that reflected R1's activity preferences and needs. R2 On August 8, 2023, at 2:17 p.m., the surveyor observed R2 outside on the patio with several other residents, performing exercises and playing catch with a ball. R2's diagnoses included dementia, hip hemiarthroplasty (partial replacement), hepatitis A, Alzheimer's disease, and osteoarthritis. R2's Service Plan, dated April 17, 2023, indicated R2 received services including assistance with bathing, dressing, grooming, toileting, cognitive	02170		

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02170	Continued From page 76 orientation, escort assistance, medication administration, bed mobility, repositioning, ambulation, transferring, safety monitoring for fall risk, activities, and meal set up. On August 10, 2023, at approximately 1:50 p.m., life enrichment coordinator (LEC)-N provided R2's AL Life Enrichment Assessment, dated April 11, 2023, identified as the annual assessment. LEC-N stated she utilized the same activity assessment and plan for all residents on the secured memory care unit. The assessment indicated R2 enjoyed playing or watching sports, camping, social events and parties, community outings, family, pets, restaurants, barbecues, music, and nature visits. Also included, R2 enjoyed trivia, jokes, storytelling, and history. R2's assessment lacked the following: - current abilities and skills; - physical abilities and limitations; and - adaptations necessary for the resident to participate. In addition, R2's record lacked an individualized activity plan based on the activity evaluation that reflected R2's activity preferences and needs. The licensee's 3.05 ALDC (assisted living with dementia care) Life Enrichment Programs, Activities & Outdoor Space policy, dated August 1, 2021, indicated each resident must be evaluated for activities according to the licensing rules of the facility and must address past and current interests, current abilities and skills, emotional and social needs and patterns, physical abilities and limitations, adaptations necessary for the resident to participate, and identification of activities for behavioral interventions. In addition, the policy directed an individualized activity plan must be developed for each resident based on their activity evaluation,	02170		

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02170	Continued From page 77 and must reflect the resident's activity preferences and needs. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02170		
02240 SS=A	144G.90 Subdivision 1 Assisted living bill of rights; notification (a) An assisted living facility must provide the resident a written notice of the rights under section 144G.91 before the initiation of services to that resident. The facility shall make all reasonable efforts to provide notice of the rights to the resident in a language the resident can understand. (b) In addition to the text of the assisted living bill of rights in section 144G.91, the notice shall also contain the following statement describing how to file a complaint or report suspected abuse: "If you want to report suspected abuse, neglect, or financial exploitation, you may contact the Minnesota Adult Abuse Reporting Center (MAARC). If you have a complaint about the facility or person providing your services, you may contact the Office of Health Facility Complaints, Minnesota Department of Health. If you would like to request advocacy services, you may contact the Office of Ombudsman for Long-Term Care or the Office of Ombudsman for Mental Health and Developmental Disabilities." (c) The statement must include contact information for the Minnesota Adult Abuse Reporting Center and the telephone number, website address, email address, mailing address, and street address of the Office of Health Facility Complaints at the Minnesota Department of	02240		

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02240	Continued From page 78 Health, the Office of Ombudsman for Long-Term Care, and the Office of Ombudsman for Mental Health and Developmental Disabilities. The statement must include the facility's name, address, email, telephone number, and name or title of the person at the facility to whom problems or complaints may be directed. It must also include a statement that the facility will not retaliate because of a complaint. (d) A facility must obtain written acknowledgment from the resident of the resident's receipt of the assisted living bill of rights or shall document why an acknowledgment cannot be obtained. Acknowledgment of receipt shall be retained in the resident's record. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a written acknowledgement of receipt of the current assisted living bill of rights was obtained for one of four residents (R2). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at 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 for services on December 8, 2021. R2's diagnoses included dementia, hip hemiarthroplasty (partial replacement), hepatitis	02240		

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	28522	A. BUILDING: _____ B. WING _____	08/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02240	Continued From page 79 A, Alzheimer's disease, and osteoarthritis. R2's Resident Contract was signed January 16, 2023. R2's Service Plan, dated April 17, 2023, indicated R2 received services including assistance with bathing, dressing, grooming, toileting, cognitive orientation, escorts, medication administration, bed mobility, repositioning, ambulation, transferring, safety monitoring for fall risk, activities, and meal set up. R2's record lacked written acknowledgement that he received the current Minnesota Bill of Rights for Assisted Living Residents, as required. On August 10, 2023, at 12:42 p.m., licensed assisted living director (LALD) stated she was not able to locate R2's written acknowledgement of receipt of the current Assisted Living Bill of Rights. The licensee's 2.05 Bill of Rights policy, dated August 1, 2021, indicated the licensee would provide the resident or the resident's representative with a written copy of the Assisted Living Bill of Rights before the date that services were first initiated. In addition, the policy included the licensee must obtain written acknowledgement of the resident's receipt of the BOR or shall document why an acknowledgement could not be obtained, and would be retained in the resident's record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02240		

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02310	Continued From page 80	02310		
02310 SS=H	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the care and services were provided according to acceptable health care and medical, or nursing standards for one of one resident (R6), whose consumer bed rail was removed without an assessment by the registered nurse (RN), and failed to ensure five of sixteen residents (R2, R3, R7, R8, R9) utilizing a consumer bed rail was installed per manufacturer guidelines. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: This resulted in an immediate correction order on August 9, 2023, at approximately 5:34 p.m. CONSUMER RAIL REMOVED	02310		

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02310	Continued From page 81 R6 R6's diagnoses included stroke, osteoporosis, weakness, difficulty speaking, edema, hypertension, overactive bladder. R6's Service Plan dated June 29, 2023, indicated the resident received the following services: assistance with bathing, compression stockings, dressing, and medication administration. R6's Bed Rail Consent dated August 2, 2023, noted R6 consented to the use of the bedrail for transfers and repositioning from and in the bed. The form was signed by occupational therapy (OT)-I. R6's AL (Assisted Living) Nursing Assessment dated June 29, 2023, and signed on July 7, 2023, and identified as the initial assessment, noted the resident had poor endurance and strength, was independent with transferring in and out of bed and with ambulation and mobility. In addition, the assessment noted the resident utilized a walker, but lacked identification of an assistive device. The assessment noted the resident was independent in moving about in bed. It noted under supporting resources for resident to get in and out of bed was "N/A [not applicable]". R6's AL Nursing Assessment dated July 18, 2023, identified as the 14 day assessment, noted the resident had poor endurance and strength, was independent with transferring in and out of bed and with ambulation and mobility, and utilized a walker. The assessment noted the resident was independent in moving about in bed. It noted under supporting resources for resident to get in and out of bed was "N/A". On August 9, 2023, at 8:30 a.m., R6 was	02310		

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02310	Continued From page 82 observed in her apartment, sitting in her recliner. R6 stated she has a bed she owns and the facility had put a M-shaped device in it for her to use to get in and out and move around; however on August 8, 2023, the maintenance person came in with the licensed assisted living director (LALD)-B and took it off her bed. She said they told her it was because they did not have a prescriber order for the use of the device. In addition, R6 stated the nurse did not come in to assess her before the device was removed. R6 stated she wanted the device back because she did not feel safe getting in and out of the bed during the night to use the bathroom without the device. R6's bed was observed to be a twin bed with a box spring and mattress, that was not adjustable. On August 9, 2023, at 8:50 a.m., licensed practical nurse (LPN)-C stated she told maintenance supervisor (MS)-G to remove the device from R6's bed after talking with registered nurse (RN)-A about the lack of an order for the device. RN-A stated she did not assess R6 for the device use before removing the device. On August 9, 2023, at 9:27 a.m., MS-G stated he did remove the device from R6's bed on August 8, 2023, after LPN-C instructed him to do so. R6's record lacked evidence the facility assessed the resident prior to the removal of the assistive device. CONSUMER RAILS On August 9, 2023, at 8:00 a.m. OT-J stated when she feels a resident would benefit from the use of a device, she talks with the nurse and together with the family, they determine if a device should be installed. OT-J stated she was	02310		

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02310	Continued From page 83 responsible for installing the M shaped device, sometimes using the maintenance staff to assist, and stated all residents with a device in the facility had been provided the M shaped device, and per the previous management company no other devices were to be used. OT-J stated the facility was utilizing this device when she began working at this facility, and had received no formal training on the installation of the device. OT-J stated maintenance staff had shown her how to install the device, and she had read the manufacturer's instructions. OT-J stated she would provide the guidelines. The Avantia m-safe Contoured Bed Rail instructions, undated, indicated instructions should be read prior to using the device. The instructions included, "Suitable for all home style beds with box springs. Do not use on any type of hospital bed that can move or be adjusted." R2 R2's diagnoses included dementia without behavioral disturbance, Alzheimer's disease, right partial hip replacement, a history of falls and osteoarthritis. R2's Service Plan dated April 17, 2023, indicated R2 received services including: escort to activities, bathing, dining setup, dressing, grooming, bed mobility, repositioning, transfer assistance, ambulation, toileting, and medication administration. R2's AL Nursing Assessment dated July 13, 2023, identified as the 90 day assessment indicated R2 utilized bilateral M rails on a hospital bed, utilized a reclining wheelchair, and transferred with a sit-to-stand lift and assist of one staff.	02310		

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02310	Continued From page 84 R2's Bed Rail Consent form dated December 22, 2021, noted R2 consented to the use of the device for improved bed mobility, and aid in repositioning. The form was signed by R2's daughter, but lacked signature from the facility staff. On August 9, 2023, at 11:01 a.m. the surveyors observed R2 had a hospital bed with a functional remote to adjust the head of the bed, and the head of the bed was noted to be elevated approximately 20 degrees. The hospital bed had bilateral M shaped consumer bed rails, securely attached to the adjustable bed frame. R2's record lacked evidence the licensee had installed the device according to manufacturer guidelines, had referred to the Consumer Product Safety Commission (CSPC) to check for recall information, and lacked information on whether the device was being utilized as a restraint. R3 R3's diagnoses included chronic kidney disease, arthritis in the knees, neuropathy in the hands and bilateral legs and feet. R3's Service Plan dated July 19, 2023, indicated R3 received services including: bathing, dressing, grooming, blood glucose testing, safety checks, and medication administration. R3's AL Nursing Assessment dated July 18, 2023, identified as the 14 day assessment, noted the resident utilized a manual wheelchair and walker, was independent with transfers, was independent with ambulation and mobility, and with moving in and out of bed. The assessment also noted R3 utilized a grab bar, and noted therapy had recommended a M rail on the right side of the	02310		

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02310	Continued From page 85 bed for transfers in and out of bed. In addition, it noted R3 had mild disorientation to person, place, or time. R3's Bed Rail Consent form dated July 7, 2023, noted R3 consented to the use of the device for bed mobility, safety, and balance. The form was signed by OT-I. On August 9, 2023, at 8:30 a.m., R3 was observed in his apartment in a chair in the living room. He stated he got a M rail put on his bed and said it is good and helps him in bed. On August 9, 2023, at 1;40 p.m., the surveyors observed R3's bed as a larger twin sized bed with a spring bed frame covered with a black mesh covering. The head of bed was raised approximately 45 degrees. The bed had an M-shaped consumer bed rail on the right side of the bed. R3's record lacked evidence the licensee had installed the device according to manufacturer guidelines, had referred to the CSPC to check for recall information, and lacked information on whether the device was being utilized as a restraint. R7 R7's diagnoses included dementia without behavioral disturbance, diabetes type II, hypertension, unspecified pain, critical lower limb ischemia (inadequate blood flow), edema, osteoarthritis, a history of falls, and glaucoma. R7's Service Plan dated February 24, 2023, indicated R7 received services including: escort to activities and meals, bathing, dressing, compression stockings, grooming, transferring,	02310		

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02310	Continued From page 86 bed mobility, toileting, and medication administration. R7's AL Assessment dated June 13, 2023, identified as a 90 day assessment, noted R7 required an M shaped consumer bed rail for independence in bed mobility, had poor strength and endurance with generalized weakness, required a toilet riser with rails, a hospital bed and anti-roll brakes on her wheelchair. R7 also required physical assist of one staff for transfers with a standing lift. R7's Bed Rail Consent dated January 18, 2022, noted R7 consented to the use of the bedrail to assist with bed mobility, safe transfers, and balance. The form was signed by a previously employed RN. On August 9, 2023, at 11:04 a.m., the surveyors observed an M shaped consumer bed rail on the right side of the hospital bed, with the head of bed elevated 10 degrees, with a functional remote to adjust the head of the bed. R7's Bed Rail Consent dated November 11, 2022, noted R7 consented to the use of the bed rail to assist with bed mobility, balance, and safe transfers. The form was signed by a previously employed RN. R7's record lacked evidence the licensee had installed the device according to manufacturer guidelines, had referred to the CSPC to check for recall information, and lacked information on whether the device was being utilized as a restraint. R8 R8's diagnoses included dementia without	02310		

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02310	Continued From page 87 behavioral disturbance, obesity, abnormalities of gait and mobility, diabetes type II, osteoarthritis, high blood pressure, back pain, and glaucoma. R8's Service Plan dated July 24, 2023, indicated the resident received services including: escort to activities and meals, bathing, dressing, grooming, transferring, bed mobility, ambulation, toileting, and medication administration. R8's AL Assessment dated July 24, 2023, identified as the 14 day and change of condition assessment, identified R8 had an M shaped consumer bed rail to assist with moving about in bed, indicated R8 had poor endurance and strength, declining dementia, required physical assist of one staff for ambulation, wheelchair mobility, and transfers. R8's Bed Rail Consent dated November 10, 2022, signed by a previously employed RN, noted R8 consented to the use of the bed rail to assist with getting up. On August 9, 2023, at 11:10 a.m., the surveyors observed an M shaped device on the left side of R8's hospital bed. One strap was attached to the frame of the adjustable hospital bed, and the other strap was attached to the stationary frame of the hospital bed. The head of the bed was not elevated, but did have a functioning remote. R8's record lacked evidence the licensee had installed the device according to manufacturer guidelines, had referred to the CSPC to check for recall information, and lacked information on whether the device was being utilized as a restraint. R9	02310		

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02310	Continued From page 88 R9's diagnoses included diabetes type II, personal history of traumatic fracture, fracture of neck, neuropathy, high blood pressure, a history of falls, osteoarthritis, and pain in the right knee and left shoulder. R9's Service Plan dated February 6, 2023 indicated the resident received the following services: assistance with bathing, compression stockings, and medication administration. R9's AL Assessment dated July 20, 2023, identified as a 90 day assessment, noted the resident utilized a M rail to promote independence in bed mobility. It noted R9 required physical assist of one staff for transfers, was non ambulatory, and was independent with the wheelchair. R9's Bed Rail Consent dated November 6, 2019, noted R9 consented to the use of the bed rail to assist with bed mobility and transfers. The form was signed by LPN-C. On August 9, 2023, at 7:57 a.m. the surveyor observed an M shaped device on the right side of R9's bed. R9's bed was observed to be a full sized bed with a mattress placed on an adjustable mattress frame. R9 stated she utilized the device to get in and out of bed, and stated the head of the bed was adjustable. The head of the bed was raised approximately 30 degrees. R9's record lacked evidence the licensee had installed the device according to manufacturer guidelines, had referred to the CSPC to check for recall information, and lacked information on whether the device was being utilized as a restraint.	02310		

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02310	Continued From page 89 On August 9, 2023, at 1:40 p.m., LALD-B, RN-A, and LPN-C stated they were not aware what the manufacturer's instructions for this device noted. They stated the previous management company required that they use this device for all types of beds. In addition, they stated they had not checked the CPSC for a recall, and were not aware of the need to do so. The licensee's Side Rails policy dated August 1, 2021, noted when side rails are in use, the RN must conduct an assessment to determine the intended purpose of the side rail and the risk of the use of the side rail. It also noted staff would determine if the side rail was considered to be safe and used consistent with manufacturer's directions, installed securely, and maintained in good operating condition. The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs), indicated "licensees should refer to individual manufacturer's guidelines for appropriate installation, maintenance and use. In addition, licensees should refer to the Consumer Product Safety Commission (CSPC) for the most up-to-date information related to portable bed side rail recall information." The United States Consumer Product Safety Commission (USCPSC) dated April 29, 2021, identified a recall involving adult portable bedrails that do not have safety retention straps to secure the bedrail to the bed frame to keep the bedrail from shifting out of place and creating a dangerous gap. This poses a serious risk for strangulation, entrapment, and death.	02310		

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02310	Continued From page 90 No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	02310		
02410 SS=D	144G.91 Subd. 13 Personal and treatment privacy (a) Residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a resident's space by knocking on the door and seeking consent before entering, except in an emergency or unless otherwise documented in the resident's service plan. (b) Residents have the right to have and use a lockable door to the resident's unit. The facility shall provide locks on the resident's unit. Only a staff member with a specific need to enter the unit shall have keys. This right may be restricted in certain circumstances if necessary for a resident's health and safety and documented in the resident's service plan. (c) Residents have the right to respect and privacy regarding the resident's service plan. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure privacy was maintained for one of two residents (R1) observed during application of topical medication.	02410		

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02410	Continued From page 91 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: R1's prescriber orders dated July 27, 2023, included, but was not limited to, diclofenac one percent (1%)- apply four grams (gm) topically to right knee four times daily, indicated for pain. Use measuring tool from in the box for dosing. On August 8, 2023, at 3:05 p.m., the surveyor observed unlicensed personnel (ULP)-D apply diclofenac gel to R1's right knee. R1 was sitting in wheelchair at the dining table in the secured unit. Four other residents were also seated at the table. Three other residents were seated on the other side of the room, and one was walking around the room. ULP-D moved R1's wheelchair back from the table approximately five feet. Then ULP-D rolled up R1's right pant leg from ankle to up over R1's knee exposing her lower leg to everyone present. ULP-D applied the diclofenac gel to R1's right knee, pulled R1's pant leg back down, and moved R1's wheelchair back up to the dining table. ULP-D stated they applied the diclofenac gel in the common area because R1 usually refuses to go back to R1's room. ULP-D did not attempt to ask R1 to go back to R1's room. On August 10, 2023, at 11:46 a.m., registered	02410		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28522	A. BUILDING: _____ B. WING _____	08/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HARBOR AT PEACE VILLAGE	300 FAXON ROAD NORTH NORWOOD YOUNG AMERIC, MN 55368

(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
02410	Continued From page 92 nurse (RN)-A stated it was never okay to apply topical medications in common areas. RN-A stated the resident should be taken to their room or other private area for any treatment or procedure, to ensure their privacy. The licensee's 7.42 Topical Application of Ointment & Cream policy, dated August 1, 2021, included, "Provide privacy for the individual." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02410		

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

Type: Full
Date: *08/09/23*
Time: 10:00:00
Report: 8041231232

Food and Beverage Establishment Inspection Report

Location:
The Harbor At Peace Village
300 Faxon Road North
Norwood Young America, MN55368
Carver County, 10

Establishment Info:
ID #: 0037727
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9524679683
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.

4-300 Equipment Numbers and Capacities

4-302.13B ***** Priority 2 *****

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

ESTABLISHMENT DOES NOT HAVE AN IRREVERSIBLE REGISTERING TEMPERATURE INDICATOR TO MEASURE THE UTENSIL SURFACE TEMPERATURE IN THE DISH MACHINES.

Comply By: 08/23/23

Surface and Equipment Sanitizers

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

Utensil Surface Temp.: = at 170 Degrees Fahrenheit
Location: harbor dish machine
Violation Issued: No

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

Utensil Surface Temp.: = at 169 Degrees Fahrenheit
Location: haven dish machine
Violation Issued: No

Utensil Surface Temp.: = at 172 Degrees Fahrenheit
Location: memory care dish machine
Violation Issued: No

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

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 35 Degrees Fahrenheit - Location: harbor 4 door cooler: garlic pasta
Violation Issued: No

Process/Item: Cold Holding
Temperature: 33 Degrees Fahrenheit - Location: harbor 4 door cooler: beef tip/gravy
Violation Issued: No

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: harbor 4 door cooler 2: coleslaw
Violation Issued: No

Process/Item: Cold Holding
Temperature: 41 Degrees Fahrenheit - Location: harbor upright cooler: milk
Violation Issued: No

Process/Item: Cold Holding
Temperature: 41 Degrees Fahrenheit - Location: harbor upright cooler: crunch salad
Violation Issued: No

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: haven cooler: chicken salad
Violation Issued: No

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

Process/Item: Cold Holding
Temperature: 41 Degrees Fahrenheit - Location: haven 2 door cooler: milk
Violation Issued: No

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: memory care cooler: milk
Violation Issued: No

Process/Item: Re-Heating
Temperature: 197 Degrees Fahrenheit - Location: haven steamer: chicken
Violation Issued: No

Process/Item: Hot Holding
Temperature: 183 Degrees Fahrenheit - Location: harbor grill: chicken
Violation Issued: No

Process/Item: Hot Holding
Temperature: 147 Degrees Fahrenheit - Location: harbor grill: pasta
Violation Issued: No

Type: Full
Date: *08/09/23*
Time: 10:00:00
Report: 8041231232
The Harbor At Peace Village

Food and Beverage Establishment Inspection Report

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

Inspection was completed with Chelsey Rahe (Dining Manager). Annette Truebenbach was the lead Health Regulation Division Nurse Evaluator completing survey.

This establishment has two commercial kitchens, The Harbor and The Haven. There is also a memory care kitchen that receives food from The Haven kitchen.

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 use
-Date marking
-Vomit clean-up procedures
-Restrictions concerning serving a highly susceptible population
-Violations on this 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 8041231232 of 08/09/23.

Certified Food Protection Manager Chelsey Rahe

Certification Number: fm113114 Expires: 09/22/25

Inspection report reviewed with person in charge and emailed.

Signed: _____

Chelsey Rahe
Dining Manager

Signed: Sarah Conboy

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