Electronically Delivered

October 4, 2024

Licensee
Minnesota Wellness Center LLC
11103 Oak Knoll Terrace North
Minnetonka, MN 55305

RE: Project Number(s) SL36098015

Dear Licensee:

On September 4, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the June 12, 2024, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

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

JMD

Electronically Delivered

July 10, 2024

Licensee
Minnesota Wellness Center LLC
11103 Oak Knoll Terrace North
Minnetonka, MN 55305

RE: Project Number(s) SL36098015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 12, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

The correction order documentation should include the following:

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

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

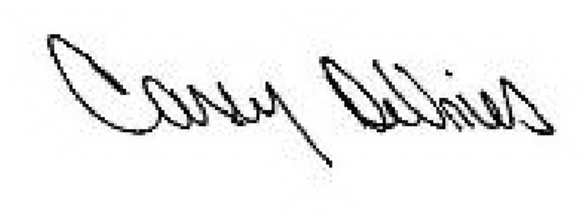
To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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

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

If you have any questions, please contact me.

Sincerely,



Casey DeVries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36098	A. BUILDING: _____ B. WING _____	06/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINNESOTA WELLNESS CENTER LLC	11103 OAK KNOLL TERRACE NORTH MINNETONKA, MN 55305

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL36098015-0 On June 10, 2024, through June 12, 2024, 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 two residents, both receiving services under the Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that:	0 470		

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0 470	Continued From page 1 (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, interview, and record review, the licensee failed to develop and implement a written staffing plan using a staffing metrics to determine appropriate staffing levels. 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	0 470		

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0 470	Continued From page 2 problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living license. The facility was licensed for a capacity of four residents, and during the survey had a census of two residents. On June 11, 2024, the licensee provided the surveyor with their untitled staffing plan for the second quarter of 2024. It lacked evidence a staffing metrics was used to determine appropriate staffing levels. The staffing plan addressed staffing needs for their maximum capacity of four residents. On June 10, 2024, at 9:40 a.m., during the entrance conference, the surveyor inquired if the licensee developed and implemented a staffing plan and evaluated the plan twice per year. Licensed assisted living director (LALD)-D stated they had a staffing plan posted upstairs along with their other required postings. On June 10, 2024, at 10:19 a.m., during the facility tour, the surveyor observed a posted staff schedule. LALD-D stated they must have had their staffing plan somewhere else, maybe in their records. On June 12, 2024, at 10:02 a.m., LALD-D stated clinical nurse supervisor (CNS)-A, LALD-D, and owner (O)-C were all involved in the development of their staffing plan. The surveyor explained the staffing plan lacked evidence of staffing metrics noted in MN Rules 4659.0180 Subp. 3., used to determine staffing levels. LALD-D stated they	0 470		

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0 470	Continued From page 3 would talk with CNS-A and O-C to bring their staffing plan into compliance. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This had the potential to affect all residents of the assisted living facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated June 10, 2024, for the specific	0 480		

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0 480	Continued From page 4 Minnesota Food Code deficiencies. The Inspection Report was provided to the licensee on June 11, 2024. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 500 SS=F	144G.41 Subd. 2 Policies and procedures Each assisted living facility must have policies and procedures in place to address the following and keep them current: (1) requirements in section 626.557, reporting of maltreatment of vulnerable adults; (2) conducting and handling background studies on employees; (3) orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; (4) handling complaints regarding staff or services provided by staff; (5) conducting initial evaluations of residents' needs and the providers' ability to provide those services; (6) conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; (7) orientation to and implementation of the assisted living bill of rights; (8) infection control practices; (9) reminders for medications, treatments, or exercises, if provided; (10) conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with	0 500		

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0 500	Continued From page 5 current United States Centers for Disease Control and Prevention standards; (11) ensuring that nurses and licensed health professionals have current and valid licenses to practice; (12) medication and treatment management; (13) delegation of tasks by registered nurses or licensed health professionals; (14) supervision of registered nurses and licensed health professionals; and (15) supervision of unlicensed personnel performing delegated tasks. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement current policies and procedures as required. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On June 10, 2024, at 7:56 a.m., the surveyor emailed the licensee that an onsite assisted living facility would be initiated on June 10, 2024, at approximately 9:30 a.m. The email indicated the licensee's policies and procedures would need to be available for review. The licensee failed to provide the following policies and procedures during or after the survey	0 500		

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0 500	Continued From page 6 process: -reporting of maltreatment of vulnerable adults. The licensee failed to provide the following policies and procedures related to current assisted living assessment requirements under 144G.70 subdivision 2. -conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate. On June 10, 2024, at 9:40 a.m., during the entrance conference, clinical nurse supervisor (CNS)-A stated they completed comprehensive nursing assessments at the following times: admission, within five days after admission, within 14 days after admission, within 90 days of the 14-day assessment, and annually thereafter. The surveyor requested the licensee's required policies and procedures which included reporting of maltreatment of vulnerable adults and nursing assessments. On June 12, 2024, at 9:44 a.m., via email, the surveyor again requested the licensee's policy that addressed nursing assessment and assessment frequency. On June 12, 2024, at 10:02 a.m., licensed assisted living director (LALD)-D stated they received the surveyor's email request for policies and procedures and would provide them as soon as possible. On June 12, 2024, at 4:42 p.m., LALD-D sent requested policies via email. The email included a	0 500		

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0 500	Continued From page 7 policy titled 4.03 Assessment-Schedule dated September 1, 2021, which included the licensee's assessments and assessment schedule but did not follow current assisted living assessment requirements under 144G.70 subdivision 2. The policy referenced 144A.4791 and 144A.4792 home care statutes, which indicated an initial individualized assessment must be completed: -within 5 days after initiation of home care services; -prior to providing medication management services; -within 14 days after initiation of home care services; -ongoing reassessments, at least every 90 days; -when the client presents with symptoms or other issues that may be medication related; -annual medication management and reassessment, at least every 12 months; and -change in client's condition. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 500		
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the	0 630		

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0 630	Continued From page 8 abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) which contained required assessment content was completed on admission for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 was admitted to the licensee on January 24, 2024. R1 was a resident at another assisted living facility (a sister facility to the licensee) prior to their admission to the licensee. R1's record included an Assisted Living Contract for Housing and Services signed on August 1, 2022. At the top of the contract, handwritten in red ink, it indicated, "Relocated From [sister facility] 1/25/24," and was initialed by licensed assisted living director (LALD)-D. R1's Service Plan dated August 2, 2019, indicated R1 received services for medication management, treatments, dressing assistance, laundry, housekeeping, bathroom reminders, and food preparation. The service plan was completed while R1 was a resident at the	0 630		

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0 630	Continued From page 9 previous facility. R1's Vulnerability Assessment/Abuse Prevention Plan dated April 28, 2022, indicated it was completed prior to R1's admission to the licensee, while they were a resident at the previous facility. On June 11, 2024, at 8:35 a.m., the surveyor observed ULP-B administer medications for R1. On June 11, 2024, at 8:43 a.m., LALD-D stated R1 was a transfer resident from one of their other facilities. On June 11, 2024, at 10:06 a.m., clinical nurse supervisor (CNS)-A stated they had not completed a new IAPP when R1 moved from the previous facility to the licensee. CNS-A stated they did not know a new one would be required when a resident transfers between their facilities. The surveyor explained a resident could not be "transferred" from one licensee to another, the resident would have to be discharged from the previous licensee then admitted to the current licensee. CNS-A, LALD-D and owner (O)-C all stated they were unaware a resident could not be transferred between facilities. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 630		
0 650 SS=D	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	0 650		

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0 650	Continued From page 10 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 observation, interview, and record review, the licensee failed to ensure employee records contained required content to include a job description and orientation and competency training documentation for one of three employees (unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include:	0 650		

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0 650	Continued From page 11 ULP-B was hired on November 29, 2023, to provide direct cares to residents. ULP-B's employee record lacked evidence of the following required content: -current job description, an Unlicensed Personnel Job Description form was included in the record but was incomplete including only the first three pages of a seven-page (3 of 7) document and lacked a signature; -orientation to assisted living statutes; -orientation to assisted living bill or rights; and -orientation to principles of person-centered planning/service delivery. ULP-B's employee record lacked evidence of required training and competency evaluations in the following topics: -documentation requirements for all services provided; -reports of changes in the resident's condition to the supervisor designated by the assisted living provider; -maintenance of a clean and safe environment; -medication, exercise, and treatment reminders; and -observation, reporting, and documenting of resident status. On June 11, 2024, at 8:35 a.m., the surveyor observed ULP-B administer medications for R1. On June 11, 2024, at 1:47 p.m., ULP-B stated they completed the above-mentioned required orientation, training, and competency evaluations when they were hired. On June 11, 2024, at 3:04 p.m., licensed assisted living director (LALD)-D and owner (O)-C both	0 650		

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MINNESOTA WELLNESS CENTER LLC	11103 OAK KNOLL TERRACE NORTH MINNETONKA, MN 55305

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0 650	Continued From page 12 stated ULP-B received the above-mentioned required orientation, training and competency evaluations but did not have it documented. Both stated they were aware of the documentation requirements. The licensee's 4.05 Employee Records policy dated August 1, 2021, indicated: "1. Employee records for each person will include: -Evidence of current professional licensure, registration or certificate, if required -Records of all training and in-service education required and/or provided including record of competency testing as required -Current signed job description, which includes qualifications, responsibilities, and identification of supervisors, if any -Documentation of annual performance reviews that identify areas of improvement needed and training needs -For individuals providing Assisted Living services, verification that required health screenings for Tuberculosis (TB) have taken place and the dates of those screenings. (recommended to keep medical information in a separate employee medical file) -Documentation of a competed criminal background study -Evidence that a reference check has been completed -Verification of completed orientation and annual training and competency testing as required." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 650		

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0 730	Continued From page 13	0 730		
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of 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	0 730		

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0 730	Continued From page 14 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 discharged resident records included a discharge summary for two of two discharged residents (R2, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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: R2 R2 was discharged from the licensee on March 7, 2024. R2's Service Plan dated January 3, 2022, indicated R2 received services for medication management, laundry, housekeeping, and food preparation. R2's record included a Resident Discharge Summary form dated March 7, 2024. It indicated the summary was completed but lacked content	0 730		

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0 730	Continued From page 15 to include the following: -a summary of the resident's stay that includes diagnoses, courses of illnesses, allergies, treatments and therapies, and pertinent lab, radiology, and consultation results; and -final summary of the resident's status from the latest assessment or review under Minnesota Statutes, section 144G.70, if applicable, which includes the resident status, including baseline and current mental, behavioral, and functional status. R4 R4 was discharged from the licensee on May 10, 2023. R4's record lacked evidence of a discharge summary. On June 11, 2024, at 12:24 p.m., licensed assisted living director (LALD)-D stated they were not sure if a discharge summary had been completed for R4. LALD-D stated the discharge happened so suddenly and the summary may not have been completed. On June 11, 2024, at 12:30 p.m., clinical nurse supervisor (CNS)-A stated they did not do a discharge assessment or summary for R4. CNS-A stated they only completed a lease termination. CNS-A stated they were aware of the discharge summary requirement. On June 11, 2024, at 1:50 p.m., LALD-D stated they did not have a discharge summary for R4. LALD-D stated they did not know they were supposed to be doing discharge summaries. The surveyor requested the licensee's discharge policy. The licensee provided a blank copy of their	0 730		

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0 730	Continued From page 16 Resident Discharge Summary form (the same as provided for R2), undated, which indicated what a discharge summary should include: "The following is the resident's discharge summary: -Provide a summary of the resident's stay that includes diagnoses, courses of illnesses, allergies, treatments, and therapies, and pertinent lab, radiology, and consultation results -Provide a final summary of the resident's status from the latest assessment or review, if applicable, which includes the resident status, including baseline and current mental, behavioral, and functional status -Provide a reconciliation of all pre-discharge medications with the resident's post-discharge prescribed and over-the-counter medications -Provide a post-discharge care plan that is developed with the resident and, with the resident's consent, the resident's representatives, which will help the resident adjust to a new living environment. The post-discharge care plan will indicate where the resident plans to reside, any arrangements that have been made for the resident's follow-up care, and any post-discharge medical and nonmedical services the resident will need. This discharge summary is provided to the resident, and, with the resident's consent, the resident's representatives, and case manager." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 730		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment	0 780		

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0 780	Continued From page 17 (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 a working smoke alarm in each sleeping room and failed to provide smoke alarms that are interconnected so that the 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 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	0 780		

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0 780	Continued From page 18 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: During the facility tour on June 10, 2024, at 11:30 a.m. with the licensed assisted living director (LALD)-D, it was observed the sleeping rooms that were equipped with smoke alarms were not interconnected upon testing, so actuation of one alarm would cause all alarms to operate. It was also observed that resident sleeping #2 on the main level, which was equipped with a smoke alarm, was not working upon testing. During the interview on June 10, 2024, at 11:30 a.m., LALD-D stated the smoke alarms in the facility were not interconnected and the actuation of one alarm would not cause all alarms to operate. 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.	0 800		

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0 800	Continued From page 19 This MN Requirement is not met as evidenced by: The licensee failed to maintain the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On June 10, 2024, at 11:30 a.m., survey staff toured the facility with the Licensed Assisted Living Director (LALD)-D. During the facility tour, survey staff observed the following items: In the living room in the basement, it was observed that there were considerable brown stains on the acoustic ceiling, which was evidence of water damage. In bedroom #4 in the basement, it was observed that the egress window was obstructed by a plastic well cover that was installed lower than the window head, and the well cover obstructed the egress window from opening fully. On the egress stair in the basement, it was observed that the stair carpet nosing was ripped and loose and was a tripping hazard.	0 800		

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0 800	Continued From page 20 During the facility tour on June 10, 2024, at 11:30 a.m., LALD-D visually verified these deficient findings at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of	0 810		

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0 810	Continued From page 21 the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a fire safety and evacuation plan with the required elements and failed to conduct required evacuation drills as required. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On June 10, 2024, at 12:30 p.m., LALD-D provided documentation on the fire safety and evacuation plan (FSEP), fire safety and evacuation training for the facility, and fire safety and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The FSEP included the following discrepancies: The FSEP indicated residents should be evacuated to the safest exit or nearest set of smoke compartment doors away from fire and smoke. This facility was a residential home and did not contain any sort of smoke compartments	0 810		

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0 810	Continued From page 22 or smoke compartment doors to contain fire and smoke. The FSEP indicated when the fire alarm is triggered, all fire doors on magnetic holders will automatically close to contain smoke and fire and residents are to remain behind these doors. The facility did not have any doors that are on magnetic door holders or doors that are rated for smoke and fire. The facility also did not have a fire alarm system that supports the use of magnetic door holders. The FSEP indicated the system was wired directly to the fire station. The facility did not have a fire alarm system that supported the direct connection to the fire station. The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The FSEP was provided by a third-party consultant, and it was not updated to meet the facility-specific layout. The FSEP included the RACE (Remove, Alarm, Confine and Extinguish or Evacuate) acronym as the fire safety procedure and instructed staff to pull the nearest fire alarm and close fire doors in case of fire, but the facility did not have a fire alarm system or fire doors. The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan failed to include ways to move, evacuate residents based on the facility's specific layout in the event of a fire or similar	0 810		

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0 810	Continued From page 23 emergency. During the interview on June 10, 2024, at 12:30 p.m., LALD-D stated the fire safety and evacuation plan was from a third-party provider and verified the facility needed to update the fire safety and evacuation plan, including the facility-specific fire safety protocols. DRILLS Record review of the available documentation indicated the licensee did not conduct evacuation drills twice per year per shift as required by statute. Provided documentation indicated drills were conducted for the first shift only, and the facility failed to provide two drills for the second and third shifts. During the interview on June 10, 2024, at 12:30 p.m., LALD-D stated drills were conducted in the morning only and confirmed that the facility did conduct two drills for the afternoon and the night shift. LALD-D verified there were no further documented drills for the facility and verified this deficient condition. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 820 SS=E	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having	0 820		

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0 820	Continued From page 24 jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide a resident bedroom with the minimum window opening meeting the minimum state standard for egress. This affected the occupied resident in bedroom #1 and #2 on the main level. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On June 10, 2024, at 11:30 a.m., survey staff toured the facility with the licensed assisted living director (LALD)-D. During the facility tour, survey staff observed the following items: It was observed unoccupied resident bedroom #1 on the main level did not have windows that met the minimum size requirements for egress escape. The clear openable area of the opened	0 820		

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0 820	Continued From page 25 windows measured 12.5 inches in height and 28.5 inches in width, with a total openable area of 356.25 square inches. The windows did not meet the minimum requirements for opening height and did not meet the minimum requirements for total openable area. It was observed unoccupied resident bedroom #2 on the main level did not have windows that met the minimum size requirements for egress escape. The clear openable area of the opened windows measured 11 inches in height and 28.5 inches in width, with a total openable area of 313.5 square inches. The windows did not meet the minimum requirements for opening height and did not meet the minimum requirements for total openable area. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. Survey staff explained to LALD-D that at least one egress window in each bedroom must be provided to meet the minimum state standard for an egress window to be a complying bedroom for resident occupancy. LALD-D verbally confirmed the findings. No Further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 820		
0 900 SS=D	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any	0 900		

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	36098	A. BUILDING: _____ B. WING _____	06/12/2024

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0 900	Continued From page 26 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 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 observation, interview, and record review, the licensee failed to execute a written contract with the required content for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 900		

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0 900	Continued From page 27 resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1 was admitted to the licensee on January 24, 2024. R1 was a resident at another another assisted living facility (a sister facility to the licensee) prior to their admission to the licensee. R1's record included an Assisted Living Contract for Housing and Services signed on August 1, 2022, by R1. At the top of the contract, handwritten in red ink, it indicated, "Relocated From [sister facility] 1/25/24," and was initialed by licensed assisted living director (LALD)-D. R1's Service Plan dated August 2, 2019, indicated R1 received services for medication management, treatments, dressing assistance, laundry, housekeeping, bathroom reminders, and food preparation. The service plan was completed while R1 was a resident at the previous facility. On June 11, 2024, at 8:35 a.m., the surveyor observed ULP-B administer medications for R1. On June 11, 2024, at 8:43 a.m., LALD-D stated R1 was a transfer resident from one of their other facilities. On June 11, 2024, at 10:06 a.m., clinical nurse supervisor (CNS)-A stated they had not completed a new contract for R1 when they moved from the previous facility to the current licensee. CNS-A stated they did not know a new	0 900		

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0 900	Continued From page 28 one would be required when a resident transfers between their facilities. The surveyor explained a resident could not be transferred from one licensee to another, the resident would have to be discharged from the previous licensee then admitted to the current licensee. CNS-A, LALD-D and owner (O)-C all stated they were unaware a resident could not be transferred between facilities. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 900		
01530 SS=D	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be	01530		

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01530	Continued From page 29 available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide employees with the initial eight (8) hours of dementia training within 160 hours of providing direct care to residents for one of three direct care employees (unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-B was hired on November 29, 2023, to provide direct cares to residents. ULP-B's employee record included a Comprehensive Home Care Orientation Training and Competencies Manual tracking form dated December 11, 2023, which indicated dementia and Alzheimer's training had been completed but did not indicate how many hours of training were completed. ULP-B's employee record included a Comprehensive Home Care Orientation Training and Competencies Manual which included three	01530		

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01530	Continued From page 30 posttests for dementia training completed on January 9, 2024, but did not indicate how many hours of training were completed. ULP-B's employee record lacked evidence of the number of hours of dementia training ULP-B received within 160 hours of providing direct care to residents. On June 11, 2024, at 8:35 a.m., the surveyor observed ULP-B administer medications for R1. On June 11, 2024, at 1:47 p.m., ULP-B stated they completed the above-mentioned required orientation, training, and competency evaluations when they were hired. On June 11, 2024, at 3:04 p.m. licensed assisted living director (LALD)-D and owner (O)-C both stated ULP-B received initial dementia training but acknowledged the number of hours spent was not documented. They stated they were now using Educare (online training platform) for dementia training which tracked hours. The licensee's 3.01 Orientation for Assisted Living Staff policy dated August 1, 2021, indicated, "12.For home care providers that provide services for persons with Alzheimer's or related disorders, all direct care staff and supervisors working with those clients must receive training that includes: a) A current explanation of Alzheimer's disease and related disorders b) Effective approaches to use to problem-solve when working with a client's challenging behaviors c) How to communicate with clients who have Alzheimer's or related disorders"	01530		

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01530	Continued From page 31 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	01530		
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 observation, 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 two residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01610		

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01610	Continued From page 32 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 problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 was admitted to the licensee on January 24, 2024. R1 was a resident at another assisted living facility (a sister facility to the licensee) prior to their admission to the licensee. R1's record included an Assisted Living Contract for Housing and Services signed on August 1, 2022. At the top of the contract, handwritten in red ink, it indicated, "Relocated From [sister facility] 1/25/24," and was initialed by licensed assisted living director (LALD)-D. R1's Service Plan dated August 2, 2019, indicated R1 received services for medication management, treatments, dressing assistance, laundry, housekeeping, bathroom reminders, and food preparation. The service plan was completed while R1 was a resident at the previous facility. R1's record lacked a comprehensive nursing assessment completed since their admission on January 24, 2024. R1's most recent Monitoring and Reassessment form provided was dated November 28, 2022, completed while they were at the previous facility. On June 11, 2024, at 8:35 a.m., the surveyor observed ULP-B administer medications for R1.	01610		

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01610	Continued From page 33 On June 11, 2024, at 8:43 a.m., LALD-D stated R1 was a transfer resident from one of their other facilities. On June 11, 2024, at 10:06 a.m., clinical nurse supervisor (CNS)-A stated they had not completed an admission assessment when R1 moved from the previous facility to the licensee, nor had they completed any assessments for R1 since they came to the licensee. CNS-A stated they did not know a new one would be required when a resident transfers between their facilities. The surveyor explained a resident could not be transferred from one licensee to another, the resident would have to be discharged from the previous licensee then admitted to the current licensee. CNS-A, LALD-D and owner (O)-C all stated they were unaware a resident could not be transferred between facilities. The licensee's 4.03 Assessment - Schedules policy dated September 1, 2021, which referenced 144A.4791 home care statutes, indicated an initial individualized assessment must be completed, "within 5 days after initiation of home care services." No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	01610		
01620 SS=F	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	01620		

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01620	Continued From page 34 as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted a comprehensive assessment within 14 days of the initiation of services and every 90 days thereafter for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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:	01620		

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01620	Continued From page 35 R1 was admitted to the licensee on January 24, 2024. R1 was a resident at another assisted living facility (a sister facility to the licensee) prior to their admission to the licensee. R1's record included an Assisted Living Contract for Housing and Services signed on August 1, 2022. At the top of the contract, handwritten in red ink, it indicated, "Relocated From [sister facility] 1/25/24," and was initialed by licensed assisted living director (LALD)-D. R1's Service Plan dated August 2, 2019, indicated R1 received services for medication management, treatments, dressing assistance, laundry, housekeeping, bathroom reminders, and food preparation. The service plan was completed while R1 was a resident at the previous facility. R1's record lacked a comprehensive nursing assessment completed within 14 days after the initiation of services and every 90 days thereafter. R1's most recent Monitoring and Reassessment form was dated November 28, 2022, completed while they were at the previous facility. R1 had lived at the current licensee for 138 days without a comprehensive nursing assessment. On June 11, 2024, at 8:35 a.m., the surveyor observed ULP-B administer medications for R1. On June 10, 2024, at 9:40 a.m., during the entrance conference, clinical nurse supervisor (CNS)-A stated they completed comprehensive nursing assessments at the following times: admission, within five days after admission, within 14 days after admission, within 90 days of the 14-day assessment and annually thereafter.	01620		

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01620	Continued From page 36 On June 11, 2024, at 8:43 a.m., licensed assisted living director (LALD)-D stated R1 was a transfer resident from one of their other facilities. On June 11, 2024, at 10:06 a.m., CNS-A stated they had not completed a five-day, 14 day, or 90-day nursing assessment since R1 moved from the previous facility to the licensee. CNS-A stated their assessment schedule only included one 90-day assessment for the residents and then they completed ongoing assessments annually or with a resident change in condition. CNS-A stated they were unaware a five-day assessment was not a statute requirement and ongoing assessments should have been completed every 90 days. CNS-A stated none of their resident records would have ongoing 90-day assessments as they did not know it was a requirement. CNS-A stated they did not know new assessments were required when a resident transferred between their facilities. The surveyor explained a resident could not be transferred from one licensee to another, the resident would have to be discharged from the previous licensee then admitted to the current licensee. CNS-A, LALD-D and owner (O)-C all stated they were unaware a resident could not be transferred between facilities. The licensee's 4.03 Assessment - Schedules policy dated September 1, 2021, which referenced 144A.4791 and 144A.4792 home care statutes, indicated an initial individualized assessment must be completed: -within 5 days after initiation of home care services; -prior to providing medication management services; -within 14 days after initiation of home care	01620		

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01620	Continued From page 37 services; -ongoing reassessments, at least every 90 days; -when the client presents with symptoms or other issues that may be medication related; -annual medication management and reassessment, at least every 12 months; and -change in clients condition. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	01620		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan.	01640		

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01640	Continued From page 38 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have a current signed service plan which identified specific services to be provided for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 was admitted to the licensee on January 24, 2024. R1 was a resident at another assisted living facility (a sister facility to the licensee) prior to their admission to the licensee. R1's record included an Assisted Living Contract for Housing and Services signed on August 1, 2022. At the top of the contract, handwritten in red ink, it indicated, "Relocated From [sister facility] 1/25/24," and was initialed by licensed assisted living director (LALD)-D. R1's Service Plan dated August 2, 2019, indicated R1 received services for medication management, treatments, dressing assistance, laundry, housekeeping, bathroom reminders, and food preparation. The service plan was completed while R1 was a resident at the previous facility. R1's record lacked a new service plan completed	01640		

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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
01640	Continued From page 39 upon admission to the licensee. On June 11, 2024, at 8:35 a.m., the surveyor observed unlicensed personnel (ULP)-B administer R1 medications. On June 10, 2024, at 9:40 a.m., during the entrance conference, licensed assisted living director (LALD)-D stated clinical nurse supervisor (CNS)-A and LALD-D developed a resident's service plan at the time of admission and as needed thereafter. On June 11, 2024, at 8:43 a.m., licensed assisted living director (LALD)-D stated R1 was a transfer resident from one of their other facilities. On June 11, 2024, at 10:06 a.m., CNS-A stated they did not know a new service plan was required when a resident transfers between their facilities. The surveyor explained a resident could not be transferred from one licensee to another, the resident would have to be discharged from the previous licensee then admitted to the current licensee. CNS-A, LALD-D and owner (O)-C all stated they were unaware a resident could not be transferred between facilities. The licensee's 4.09 Service Plans policy, dated August 1, 2021, indicated: "-The assisted living provider shall finalize a written service plan within14 days after the initiation of home care services to a client. -The service plan and any revisions must include a signature or other authentication by the home care provider and by the client or the client's representative documenting agreement on the services to be provided. -The service plan must be revised, if needed, based on the results of required client monitoring	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36098	A. BUILDING: _____ B. WING _____	06/12/2024

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01640	Continued From page 40 and/or reassessments." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	01640		
01700 SS=D	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced	01700		

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01700	Continued From page 41 by: Based on observation, interview, and record review, the licensee failed to ensure a medication management assessment was completed by the registered nurse (RN) prior to providing medication management services for one of two residents (R1) receiving medication management 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) 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 was admitted to the licensee on January 24, 2024. R1 was a resident at another assisted living facility (a sister facility to the licensee) prior to their admission to the licensee. R1's record included an Assisted Living Contract for Housing and Services signed on August 1, 2022. At the top of the contract, handwritten in red ink, it indicated, "Relocated From [sister facility] 1/25/24," and was initialed by licensed assisted living director (LALD)-D. R1's Service Plan dated August 2, 2019, indicated R1 received services for medication management, treatments, dressing assistance, laundry, housekeeping, bathroom reminders, and food preparation. The service plan was completed while R1 was a resident at the previous facility.	01700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36098	A. BUILDING: _____ B. WING _____	06/12/2024

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01700	Continued From page 42 R1's record included a MWC Medication Assessment form dated July 25, 2023, which was completed while R1 was a resident at the previous facility. It indicated R1 was, "deemed UNABLE to safely administer medications for the following reasons: memory impairment, forgetfulness." R1's Physician's Order Report dated June 11, 2024, indicated R1 took the following medications: -Advair HFA Inhalation Aerosol 115-21 micrograms/active ingredient (mcg/act); -acetaminophen tablet 325mg; -albuterol sulfate inhalation aerosol 108mcg/act; -cyclobenzaprine HCL tablet 5mg; -docusate sodium capsule 100mg; -ferrous sulfate oral tablet 325 milligrams (mg); -finasteride oral tablet 5mg; -folic acid 1000mcg; -naltrexone hydrochloride (HCL) oral tablet 50mg; -nicotine polacrilex mouth/throat lozenge 4mg; -nicotine transdermal 24-hour patch, 21mg/24 hours; -omeprazole delayed release capsule 40mg; -oxycodone HCL tablet 5mg; -pregabalin capsule 25mg; -quetiapine fumarate tablet 25mg; -tamsulosin HCL capsule 0.4mg; -terbinafine HCL external cream 1%; -vitamin B1 tablet 100mg; and -Xarelto tablet 20mg. R1's record lacked a medication management assessment completed prior to providing medication management services upon admission to the licensee on January 24, 2024. On June 11, 2024, at 8:35 a.m., the surveyor observed unlicensed personnel (ULP)-B	01700		

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01700	Continued From page 43 administer R1's medications. On June 11, 2024, at 8:43 a.m., licensed assisted living director (LALD)-D stated R1 was a transfer resident from one of their other facilities. On June 11, 2024, at 10:06 a.m., clinical nurse supervisor (CNS)-A stated they did not complete a medication management assessment when R1 was admitted to the licensee. CNS-A stated they did not know a new medication management assessment needed to be completed when a resident transferred between facilities. The surveyor explained a resident could not be transferred from one licensee to another, the resident would have to be discharged from the previous licensee then admitted to the current licensee. CNS-A, LALD-D and owner (O)-C all stated they were unaware a resident could not be transferred between facilities. The licensee's 7.01 Medication Management - Assessment, Monitoring and Reassessment policy dated August 1, 2021, indicated, "prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber conduct an assessment to determine what medication management services will be provided and how the services will be provided." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01700		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan	01730		

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	36098	A. BUILDING: _____ B. WING _____	06/12/2024

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01730	Continued From page 44 (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing	01730		

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01730	Continued From page 45 medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to identify how a resident's medications would be stored, who would monitor medication supplies, and who would reorder medication for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 was admitted to the licensee on January 24, 2024. R1 was a resident at another assisted living facility (sister facility to the licensee) prior to their admission to the licensee. R1's record included an Assisted Living Contract for Housing and Services signed on August 1, 2022. At the top of the contract, handwritten in red ink, it indicated, "Relocated From [sister facility] 1/25/24," and was initialed by licensed assisted living director (LALD)-D. R1's Service Plan dated August 2, 2019, indicated R1 received services for medication management, treatments, dressing assistance, laundry, housekeeping, bathroom reminders, and food preparation. The service plan was completed while R1 was a resident at the	01730		

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01730	Continued From page 46 previous facility. R1's record included a MWC Medication Assessment form dated July 25, 2023, which was completed while R1 was a resident at the previous facility. It indicated R1 was, "deemed UNABLE to safely administer medications for the following reasons: memory impairment, forgetfulness." R1's Physician's Order Report dated June 11, 2024, indicated R1 took the following medications: -Advair HFA Inhalation Aerosol 115-21 micrograms/active ingredient (mcg/act); -acetaminophen tablet 325mg; -albuterol sulfate inhalation aerosol 108mcg/act; -cyclobenzaprine HCL tablet 5mg; -docusate sodium capsule 100mg; -ferrous sulfate oral tablet 325 milligrams (mg); -finasteride oral tablet 5mg; -folic acid 1000mcg; -naltrexone hydrochloride (HCL) oral tablet 50mg; -nicotine polacrilex mouth/throat lozenge 4mg; -nicotine transdermal 24-hour patch, 21mg/24 hours; -omeprazole delayed release capsule 40mg; -oxycodone HCL tablet 5mg; -pregabalin capsule 25mg; -quetiapine fumarate tablet 25mg; -tamsulosin HCL capsule 0.4mg; -terbinafine HCL external cream 1%; -vitamin B1 tablet 100mg; -Xarelto tablet 20mg; R1's record lacked an individualized medication management plan when they began receiving medication management services upon admission to the licensee on January 24, 2024.	01730		

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01730	Continued From page 47 On June 11, 2024, at 8:35 a.m., the surveyor observed unlicensed personnel (ULP)-B administer R1 medications. On June 11, 2024, at 8:43 a.m., licensed assisted living director (LALD)-D stated R1 was a transfer resident from one of their other facilities. On June 11, 2024, at 10:06 a.m., clinical nurse supervisor (CNS)-A stated they did not complete an individualized medication management plan when R1 was admitted to the licensee. CNS-A stated they did not know a new individualized medication management plan needed to be completed when a resident transferred between facilities. The surveyor explained a resident could not be transferred from one licensee to another, the resident would have to be discharged from the previous licensee then admitted to the current licensee. CNS-A, LALD-D and owner (O)-C all stated they were unaware a resident could not be transferred between facilities. The licensee's 7.01 Medication Management - Assessment, Monitoring and Reassessment policy dated August 1, 2021, indicated, "prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber conduct an assessment to determine what medication management services will be provided and how the services will be provided." No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days.	01730		

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

Type: Full
Date: *06/10/24*
Time: 12:00:00
Report: 8041241101

Food and Beverage Establishment Inspection Report

Location:
Minnesota Wellness Center Llc
11103 Oak Knoll Terrace North
Minnetonka, MN55305
Hennepin County, 27

Establishment Info:
ID #: 0037870
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6126185841
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.

2-100 Supervision

2-102.12DMN

MN Rule 4626.0033D Post the certified food protection manager certificate.

PHOTO COPY OF CERTIFIED FOOD PROTECTION MANAGER CERTIFICATE POSTED. POST ORIGINAL CERTIFICATE.

Comply By: 06/24/24

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.12A

MN Rule 4626.1520A Clean and maintain all physical facilities clean.

CEILING & WALL ABOVE STOVE IS SOILED WITH DUST AND GREASE BUILD-UP.

Comply By: 06/17/24

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 37 Degrees Fahrenheit - Location: whirlpool refrigerator: milk
Violation Issued: No

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

Inspection was completed with Abdillahi Adan Farah-Abrar. Joey Keen was the lead Health Regulation Division Nurse Evaluator. Facility had one residents on site at time of inspection.

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

A two basin sink is located in the kitchen with one basin designated for handwashing. Establishment has a Residential NSF dishwasher that has a sani rinse/high temp cycle and achieved a temp. at least 160F for sanitizing dishes.

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

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 8041241101 of 06/10/24.

Certified Food Protection Manager: Abdillahi Adan Farah-Abrar

Certification Number: fm113472 Expires: 10/25/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
Abdillahi Adan Farah-Abrar

Signed: Sarah Conboy

Sarah Conboy
Public Health San. Supervisor
651-201-3984
sarah.conboy@state.mn.us