



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

June 26, 2024

Licensee
Tranquil Living
2521 Wilshire Boulevard
Mound, MN 55364

RE: Project Number(s) SL34050015

Dear Licensee:

On June 17, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the March 21, 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

AH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34050	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 06/17/2024
NAME OF PROVIDER OR SUPPLIER TRANQUIL LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 2521 WILSHIRE BOULEVARD MOUND, MN 55364			
(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 INITIAL COMMENTS: SL34050015-1 On June 17, 2024, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on March 21, 2024. At the time of the survey, there were four (4) residents; three (3) receiving services under the Assisted Living license. As a result of the follow-up survey, the licensee is in substantial compliance.	{0 000}			
{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}			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

April 11, 2024

Licensee
Tranquil Living
2521 Wilshire Boulevard
Mound, MN 55364

RE: Project Number(s) SL34050015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on March 21, 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 . . ."

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), MDH may impose fine amounts of either \$1,000 or \$5,000 to licensees who are found to be responsible for maltreatment. 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. 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 - 0820 - 144g.45 Subd. 2 (g) - Fire Protection And Physical Environment = \$3,000.00

St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required S-S= \$3,000.00

St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services S-S= \$3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$9,000.00**. 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.

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>

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the

correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. to submit a hearing request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

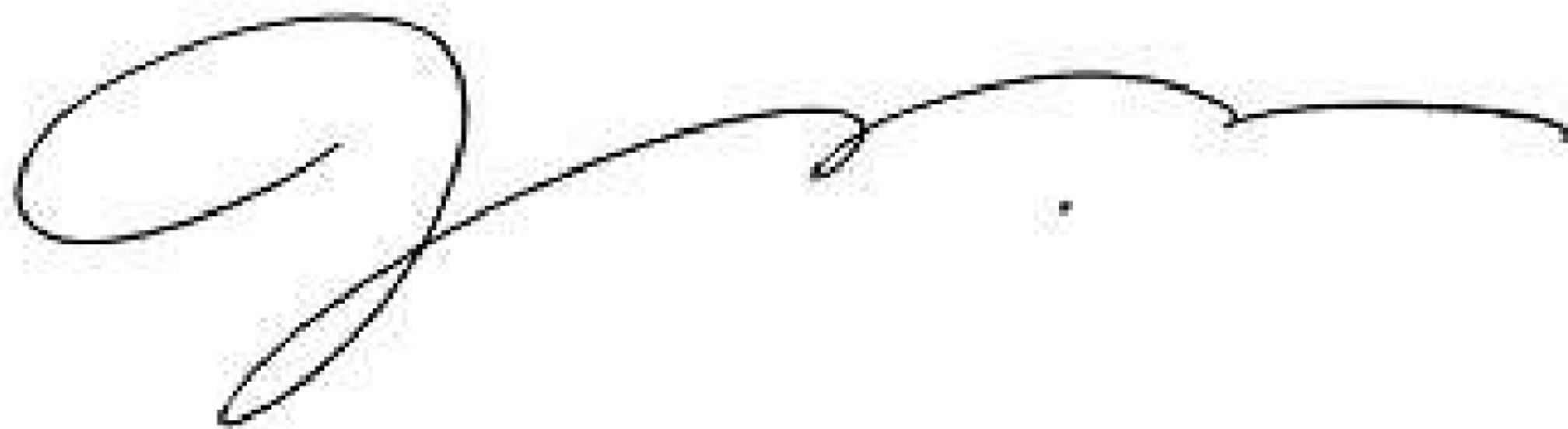
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms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

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/Bm5uQEpHV>**. 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,

A handwritten signature in black ink, appearing to read 'Jess Schoenecker', with a stylized flourish extending to the right.

Jess Schoenecker, Supervisor

State Evaluation Team

Email: jess.schoenecker@state.mn.us

Telephone: 651-201-3789 Fax: 1-866-890-9290

PMB

Minnesota Department of Health

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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: SL34050015-0 On March 19, 2024 through March 21, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were four (4) residents receiving services under the Assisted Living license. An immediate correction order was identified on March 19, 2024, issued for SL34050015, tag identification 0820. The immediacy of order 0820 was removed on March 20, 2024, at 9:24 a.m. The scope and level remain unchanged. Immediate correction orders were identified on March 20, 2024, issued for SL34050015, tag identifications 1290 and 2310. The immediacy of orders 1290 and 2310 was removed on March 21, 2024, at 6:20 p.m. The	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.		

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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0 000	Continued From page 1 scopes and levels remain unchanged.	0 000			
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	0 250			

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0 250	Continued From page 2 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; (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 observation, interview, and record review, the licensee failed to ensure the management officials who were in charge of the day-to-day operations; and responsible for the resident's assisted living services, understood all of the assisted living facility regulations. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client'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 clients).	0 250			

Minnesota Department of Health

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0 250	Continued From page 3 The findings include: The licensee's "Application for Assisted Living License", section titled "Official Verification of Owner or Authorized Agent", (page three and four 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 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 f a management agreement or subcontract."	0 250			

Minnesota Department of Health

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0 250	Continued From page 4 - "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), in place upon licensure and to keep them current as applicable." Page four was electronically signed by the owner identified as licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C for the purpose of this survey on April 20, 2023. The licensee had an assisted living license, effective until June 1, 2024. Twenty-five (25) correction orders with three (3) being immediate correction orders were issued, which indicated the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.01 to 144G.95. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250			
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:	0 480			

Minnesota Department of Health

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0 480	Continued From page 5 (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) 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 document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated March 19, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			
0 510 SS=D	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	0 510			

Minnesota Department of Health

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0 510	Continued From page 6 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 infection control (IC) program that complies with accepted health care, medical and nursing standards for infection control. The deficient practice had the potential to affect residents, employees, 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 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: Unlicensed personnel (ULP)-A was hired on May 23, 2023. ULP-A's My Transcript dated October 28, 2023, indicated ULP-A completed training for, "Test Only - Infection Prevention and Control - PPE (personal protection equipment)." On March 19, 2024, at 12:30 a.m., ULP-A stated	0 510			

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0 510	Continued From page 7 all staff are trained by licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C for all required content. Additionally, all staff then complete training online through licensee's training program. On March 20, 2024, at 7:30 a.m., during continuous observations, ULP-A donned (put on) and doffed (took off) gloves multiple times without completion of hand hygiene prior to and immediately after glove use. ULP-A entered R1's room and assisted R1 with activities of daily living (ADLs) for R1's morning routine. ULP-A would don and doff gloves multiple times without hand hygiene. After removing gloves, ULP-A exited R1's room and proceeded to the kitchen area where ULP-A gathered supplies for R1's morning medication administration. ULP-A proceeded to don gloves without hand hygiene and provided medications to R1 at the common area kitchen table. After completion of medication administration to R1, ULP-A doffed gloves and gather supplies for making breakfast for residents in the home. On March 21, 2024, at 12:00 p.m., LALD/CNS-C stated the licensee's expectations are all staff are to complete hand hygiene before and after glove use. LALD/CNS-C stated ULP-A would be retrained for hand hygiene and infection control. The licensee's 8.07 Gloves policy dated July 1, 2021, indicated employees would wash hands prior to and immediately after each glove use. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510			

Minnesota Department of Health

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0 550	Continued From page 8	0 550			
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the Office of Ombudsman for Long Term Care (OOLTC), Office of Ombudsman for Mental Health and Developmental Disabilities (OOLTC), Minnesota Adult Abuse Reporting Center (MAARC), and contact information for the individual(s) who were responsible for handling resident grievances was posted in a conspicuous place as required. This had the potential to affect all the licensee's current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to	0 550			

Minnesota Department of Health

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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
0 550	Continued From page 9 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 clients). The findings include: On March 19, 2024, at 10:20 a.m., during a tour, the licensee failed to post in a conspicuous place the following required information: - the person responsible for handling grievances; - contact information for the OOLTC and the OOMHDD; - information for the MAARC; and - information for the Office of Health Facility Complaint (OHFC). On March 21, 2024, at 12:00 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated licensee was not aware of the required postings. LALD/CNS-C stated the required information was provided to each resident in their contracts, but the information was not posted in a conspicuous place to access. The licensee's undated 2.10 Complaint/Grievance Posting policy indicated the required information for the person who handled grievances, OOLTC, OOMHDD, and MAARC would all be posted in a conspicuous place. However, the policy failed to indicate the information for OHFC would be posted in a conspicuous place. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550			

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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 (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post the 911 emergency number in common areas and near telephones provided by the assisted living facility. 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). The findings include: On March 19, 2024, at 10:20 a.m., during a tour, the surveyor did not observe the 911 emergency	0 640			

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0 640	Continued From page 11 number in common areas and near the telephone in the common area. On March 21, 2024, at 12:00 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated licensee was not aware of the required postings. LALD/CNS-C stated the required information was provided to each resident in their contracts, but the information was not posted near the telephones in the common area. The licensee's Emergency Preparedness Plan dated July 1, 2021, indicate the emergency phone number to dial would be 911, however the plan failed to indicate the 911 number would be posted in the common area and by the common area telephones. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640			
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 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	0 650			

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0 650	Continued From page 12 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 included all required content for one of two employees (unlicensed personnel (ULP)-A). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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-A was hired on May 31, 2023. ULP-A's employee record lacked evidence of a job description, including qualifications, responsibilities, and identification of staff persons providing supervision. On March 21, 2024, at 12:00 p.m., licensed assisted living director/clinical nurse supervisor	0 650			

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0 650	Continued From page 13 (LALD/CNS)-C stated ULP-A's missing employee record content was an oversight by licensee. LALD/CNS-C stated they were not sure why items were missing but would audit employee records to ensure the required content would be included in each employee's record. The licensee's 4.05 Employee Records policy dated July 1, 2021, indicated each employee record would include a, "current signed job description, which includes qualifications, responsibilities, and identification of supervisors, if any." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650			
0 660 SS=D	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.	0 660			

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0 660	Continued From page 14 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document completion of a baseline tuberculosis (TB) screening at the time of hire or prior to providing services to residents for one of three unlicensed personnel ((ULP)-A). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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-A was hired on May 23, 2023. On March 19, 2024, at 2:17 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C provided ULP-A's record and indicated entire employee record was included. ULP-A's employee record lacked a TB screening and results at the time of hire. On March 21, 2024, at 12:00 p.m., LALD/CNS-C stated all employees were to be screened and test results would be maintained in each employee's record. LALD/CNS-C stated licensee did not know why ULP-A's TB screening and results were missed as other employees' screenings and results were all completed and in each employee's record. The licensee's 8.16 Tuberculosis Screening	0 660			

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0 660	Continued From page 15 policy dated July 1, 2021, indicated each employee would be screen and tested for TB with the results maintained in each employee's record. No further information 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 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	0 680			

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0 680	Continued From page 16 by: Based on observation, interview, and record review, the licensee failed to have a written emergency preparedness plan with all the required content in the facility and failed to post an emergency preparedness plan prominently. This had the potential to impact all residents, staff, and visitors to the 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, 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 March 19, 2024, at 10:20 a.m., during a tour, the surveyor did not observe an emergency disaster plan posted in a prominent location and maintained an emergency plan at the facility. On March 20, 2024, at 11:40 a.m., unlicensed personnel (ULP)-A stated licensee does not maintain an emergency preparedness plan at the facility. ULP-A stated all emergency training occurred during orientation. ULP-A stated if there is a fire, staff are trained to remove people from the building and if there was a severe storm, would move people away from windows. On March 21, 2024, at 12:00 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated although licensee had developed an emergency preparedness plan, licensee did not maintain a physical copy at the	0 680			

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0 680	Continued From page 17 facility and did not post one in a prominent location within the building. LALD/CNS-C stated licensee would need to develop a physical copy and post in the facility. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 790 SS=C	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide or maintain fire extinguishers as required throughout the facility. This deficient condition had the ability to affect all staff, visitors, and residents. 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	0 790			

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0 790	Continued From page 18 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On a facility tour on March 19, 2024, at 10:35 a.m., licensed assisted living director/ clinical nurse supervisor (LALD/ CNS)-A, it was observed that the required fire extinguisher was provided but not mounted on the wall as required by Minnesota Fire Code in Minnesota Rules Chapter 7511. At least one fire extinguisher with minimum 2-A:10-B:C rating is required to be provided, mounted, maintained, and located within 75 feet of travel throughout the facility. Fire extinguishers are required to be mounted at least 4 inches off the floor and not higher than 60 inches from the floor to the top of the extinguisher. Documentation is required to demonstrate fire extinguishers have been inspected by facility personnel monthly, and annually replaced with a new extinguisher (of current year manufacture date) or serviced by a certified technician. During interview on March 20, 2024, at 9:40 a.m., LALD/ CNS-A, stated the fire extinguisher and its mount were knocked off the wall by the door and needed to be re-mounted. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 790			

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0 800	Continued From page 19	0 800			
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 facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. 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). Findings include: On a facility tour on March 19, 2024, at 10:45 a.m., with licensed assisted living director/ clinical nurse supervisor (LALD/ CNS)-A, the surveyor made the following observations of facility hazards and disrepair: Electrical switch and outlet covers were missing	0 800			

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0 800	Continued From page 20 in resident sleeping room number 1. Electrical switch and outlet covers are required to be maintained as installed at the time of construction approval to prevent accidental contact with electrical current by the building occupants. A bi-fold door leaning on the wall and other general storage was observed in the exit path in the basement hallway. Exit paths are required to be maintained free of storage and items that impede immediate and full use of the exit path during a fire or similar emergency evacuation. The battery shipping plastic was still installed on the smoke alarm on the wall in the basement hallway. The shipping plastic is required to be removed at the time of installation in order to activate the battery in accordance with the smoke alarm manufactures instructions. During an interview on March 20, 2024, at 9:35 a.m., LALD/ CNS-A, verified the above listed observations. 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	0 810			

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0 810	Continued From page 21 (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 observation, interview and record review, the licensee failed to develop the fire safety and evacuation plan with required content, make the plan readily available, provide required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	0 810			

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0 810	Continued From page 22 or has potential to affect a large portion or all of the residents). The findings include: On March 20, 2024, at 9:30 a.m., licensed assisted living director/ clinical nurse supervisor (LALD/ CNS)-A, provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee FSEP updated July 1, 2023, failed to include the following: The location and number of resident sleeping rooms was included on the fire evacuation floor plan but not on or adjacent to the resident room doors of the facility. The resident room numbers are required to be installed on or adjacent to the doors in conjunction with the posted floor plan to provide communication and directions during a fire or similar emergency evacuation. 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 not updated to include specific employee actions required for this facility. The FSEP policy inaccurately included information that was not applicable to this specific facility. The FSEP did not identify specific fire protection actions for residents as evident by not including specific written procedures required of residents during a fire or similar emergency.	0 810			

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0 810	Continued From page 23 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 the evacuation status and unique needs for each individual resident in writing and available for reference by staff during an emergency evacuation. During an interview on March 20, at 10:00 a.m., LALD/ CNS-A, stated the items listed above were not included in the FSEP. TRAINING Record review indicated the licensee failed to provide training to employees on the FSEP upon hire and at least twice per year as evident by providing training records from 2018, 2019, 2020 and 2021, no documentation for recent employee training was provided. Employee training based on the facility FSEP is required to be completed and documented separate from fire drills. During an interview on March 20, 2024, at 10:05 a.m., LALD/ CNS-A, stated recent employee training records were not available. DRILLS Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month as evident by providing documentation fire drills were completed every third month and no time was documented to verify fire drills were completed twice per year per	0 810			

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0 810	Continued From page 24 shift. During an interview on March 20, 2024, at 10:10 a.m., LALD/ CNS-A, stated they were used to requirements for a different type of license and, drill records were not available indicating drills were completed every other month and twice per year per shift. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810			
0 820 SS=H	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide facilities that were not a distinct hazard to life. This had the potential to directly affect more than a limited number of the residents, staff and visitors. This practice resulted in a level three violation (a	0 820			

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0 820	Continued From page 25 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). Findings include: On a facility tour on March 19, 2024, at 10:45 a.m., with licensed assisted living director/ clinical nurse supervisor (LALD/CNS)-C and unlicensed personnel (ULP)-A, it was observed that compliant emergency escape and rescue openings were not provided in resident sleeping rooms number 2, 4 and, 5. Occupied Resident Rooms Resident sleeping room number 2, occupied by R2, emergency escape and rescue clear window opening measurements are 18 ½ inches wide, 50 inches in height, and 925 square inches, in openable area. The window was measured with ULP-A, and survey staff present. The window did not meet the minimum requirements for clear opening width. Resident sleeping room number 4, occupied by R3, emergency escape and rescue clear window opening measurements are 16 ¼ inches wide, 41 ½ inches in height, and 674 square inches, in openable area. The window was measured with ULP-A, and survey staff present. The window did not meet the minimum requirements for clear opening width. Unoccupied Room	0 820			

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0 820	Continued From page 26 Resident sleeping room number 5, unoccupied, emergency escape and rescue clear window opening measurements are 16 ¼ inches wide, 41 ½ inches in height, and 674 square inches, in openable area. The window was measured with ULP-A, and survey staff present. The window did not meet the minimum requirements for clear opening width. It was explained to LALD/ CNS-C and, ULP-A, that at least one compliant emergency escape and rescue opening is required within each resident sleeping room. Existing emergency escape and rescue openings are required to meet a minimum clear opening area of 648 square inches and have a minimum dimension of 20 inches in height and a minimum dimension of 20 inches in width. And have a windowsill height from the floor to the clear opening of not more than 48 inches. Interior Wall Finishes On the same tour it was observed that indoor/ outdoor carpet was installed as a protective wainscoting in most of the main floor living area including exit pathways. This carpet is not designed with the required fire resistance for an interior wall finish and will cause toxic smoke and fire in the exit paths during an interior fire. Interior wall finishes are required to meet the surface burning characteristics required by Minnesota Fire Code in Minnesota Rules Chapter 7511. Used Cigarette Butts Disposal On the same tour it was observed that used cigarette butts were discarded in a plastic bucket	0 820			

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0 820	Continued From page 27 on the wood deck. There was an appropriate dispenser in the same location on the wood deck. Used cigarette butts are required to be discarded in an appropriate container according to the facility smoking policy. These deficient conditions were visually verified by ULP-A, accompanying on the tour. Survey staff explained that an immediate correction order was issued for the non-compliant emergency escape windows. TIME PERIOD FOR CORRECTION: Immediate. The immediacy of order 0820 was removed on March 20, 2024, at 9:24 a.m. The scope and level remain unchanged.	0 820			
01290 SS=G	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by:	01290			

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01290	Continued From page 28 Based on interview and record review, the licensee failed to ensure current employee records contained all the required content to include a Department of Human Services (DHS) Netstudy 2.0 background study (BGS) clearance letter for one of two employees, (unlicensed personnel (ULP)-B). 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: ULP-B was hired on May 23, 2023, to provide direct care services to residents of the assisted living facility. ULP-B's record lacked a completed and cleared BGS. On March 19, 2023, at 11:15 a.m., surveyor spoke on the phone with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C to requested ULP-B's full employee record. LALD/CNS-C stated all employee records were stored on LALD/CNS-C's computer and would email ULP-B's full employee record. On March 19, 2023, at 2:17 p.m., LALD/CNS-C sent an email which noted, "I just notice that I I (sic) didn't submit [ULP-B]'s background. I'm running it right now."	01290			

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01290	Continued From page 29 On March 19, 2023, at 8:17 p.m., LALD/CNS-C sent an email which noted, "[ULP-B]'s background is pending finger printing so [ULP-B] will get it done tomorrow." The screenshot from DHS Netstudy 2.0 dated March 20, 2024, at 7:57 a.m., showed ULP-B's DHS Netstudy 2.0 BGS was initiated, and ULP-B was affiliated with licensee on March 19, 2024, however, was still in process. On March 20, 2024, at 8:30 a.m., LALD/CNS-C stated licensee was aware of the DHS BGS requirement but missed ULP-B's when they were hired. LALD/NS-C stated licensee initiated ULP-B's DHS BGS and fingerprinting would be completed as soon as possible. LALD/CNS-C stated ULP-B would require direct supervision until ULP-B's background study was completed and cleared. The licensee's 4.02 Background Studies policy dated July 1, 2021, indicated all employees would have a cleared BGS from DHS's Netstudy program prior to providing services to residents. No further information provided. TIME PERIOD FOR CORRECTION: Immediate The immediacy of order 1290 was removed on March 21, 2024, at 6:20 p.m. The scope and level remain unchanged.	01290			
01370 SS=F	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following:	01370			

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01370	Continued From page 30 (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on interview and record review, the	01370			

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01370	Continued From page 31 licensee failed to ensure competencies were completed and documented for two of two unlicensed personnel ((ULP)-A, ULP-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-A was hired on May 31, 2023. ULP-B was hired on May 23, 2023. ULP-A and ULP-B's My Transcript dated October 28, 2023, and March 19, 2024, respectively, indicated ULP-A and ULP-B had been trained in all required areas, but lacked evidence of competency training for the following required areas: - appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; - standby assistance techniques and how to perform them. On March 21, 2024, at 12:00 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated licensee had not completed and documented the required competencies for	01370			

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01370	Continued From page 32 employees. LALD/CNS-C stated licensee would need to identify the required competencies and complete each ULP's training. The licensee's 5.02 Competency Training Evaluations policy dated July 1, 2021, indicated training and competency evaluations for all ULPs would include the identified missing competencies. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370			
01380 SS=F	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on interview and record review, the	01380			

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01380	Continued From page 33 licensee failed to ensure competencies were completed and documented for two of two unlicensed personnel ((ULP)-A, ULP-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-A was hired on May 31, 2023. ULP-B was hired on May 23, 2023. ULP-A and ULP-B's My Transcript dated October 28, 2023, and March 19, 2024, respectively, indicated ULP-A and ULP-B had been trained in all required areas, but lacked evidence of competency training for the following required areas: - reading and recording temperature, pulse, and respirations of the resident; - safe transfer techniques and ambulation; - range of motioning and positioning; and - administering medications or treatments as required. On March 21, 2024, at 12:00 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated licensee had not completed and documented the required competencies for employees. LALD/CNS-C stated licensee would need to identify the required competencies and complete each ULP's training.	01380			

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01380	Continued From page 34 The licensee's 5.02 Competency Training Evaluations policy dated July 1, 2021, indicated training and competency evaluations for all ULPs would include the identified missing competencies. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380			
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer.	01440			

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01440	Continued From page 35 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 supervision of a ULP within 30 calendar days of beginning to provide delegated tasks for two of two unlicensed personnel ((ULP)-A, ULP-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-A was hired on May 31, 2023. ULP-A's My Transcript dated October 28, 2023, indicated ULP-A had been trained in medications and treatment administration. ULP-A's record lacked evidence ULP-A had a supervision visit by the registered nurse (RN) within 30 days of being delegated nursing and treatment tasks. ULP-B was hired on May 23, 2023. ULP-B's My Transcript dated March 19, 2024, indicated ULP-B had been trained in medications and treatment administration. ULP-B's record lacked evidence ULP-B had a supervision visit by the RN within 30 days of	01440			

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01440	Continued From page 36 being delegated nursing and treatment tasks. On March 20, 2024, at 8:00 a.m., observed ULP-A provide medication administration to R1. ULP-A obtained R1's medications from medication cart, opened medications from bubble pack, provided medication to R1, and documented administration of medication in R1's record. ULP-A stated they were trained for medication and treatment administration by licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C. On March 21, 2024, at 12:00 p.m., LALD/CNS-C stated they had observed ULP-A and ULP-B many times for medication and treatment administration, but licensee was not aware documentation of the supervisory visits within 30 days was required to be maintained in the employee record. LALD/CNS-C stated licensee would need to implement a documentation tracking system to ensure all employees' records would include evidence of the 30-day supervisory visits by LALD/CNS-C. The licensee's 6.17 Supervision of Staff - Delegated Services policy dated July 1, 2021, indicated licensee's registered nurse or appropriate licensed health care professional would provide supervision of ULPs performing delegated tasks within 30 calendar days. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440			
01470 SS=F	144G.63 Subd. 2 Content of required orientation	01470			

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01470	Continued From page 37 (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation 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	01470			

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01470	Continued From page 38 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 the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure orientation with all the required content was completed for two of two employees (unlicensed personnel (ULP)-A, 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 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: ULP-A was hired on May 31, 2023. ULP-B was hired on May 23, 2023. ULP-A and ULP-B's My Transcript dated October	01470			

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01470	Continued From page 39 28, 2023, and March 19, 2024, respectively, indicated licensee failed to orientate ULP-A and ULP-B to an introduction and review of the facility's policies and procedures related to the provision of assisted living services. On March 21, 2024, at 12:00 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated licensee had not provided specific training to ULP-A and ULP-B on the licensee's policies and procedures. LALD/CNS-C stated licensee was not aware of the required orientation. The licensee's 4.18 Employee General Orientation policy dated July 1, 2021, indicated all employees would be orientated to licensee's policy and procedures. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470			
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	01530			

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01530	Continued From page 40 hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received the required hours of dementia care training for one of two unlicensed personnel ((ULP)-A). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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-A was hired on May 31, 2023. ULP-A's My Transcript dated October 28, 2023, identified by licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C as ULP-A's complete training record, indicated	01530			

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01530	Continued From page 41 ULP-A completed one (1) hour of dementia care training. On March 21, 2024, at 12:00 p.m., LALD/CNS-C stated licensee had operated under a previous licensing requirement which did not require dementia care training. LALD/CNS-C stated ULP-A had been initially assigned eight (8) hours of dementia care training, but licensee removed the assigned classes to ULP-A due to confusion with a different license. LALD/CNS-C stated licensee would need to reassign the required 8 hours of dementia care training to ULP-A and would audit all staff to ensure the required hours were completed. The licensee's 5.03 Dementia Training policy dated July 1, 2021, indicated direct care employees would complete 8 hours of dementia care training prior to being able to provide direct care to residents. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530			
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 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	01620			

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01620	Continued From page 42 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN) completed comprehensive assessments and reassessments within the required time frames and failed to include all required content identified per Minnesota Administrative Rule 4659.0150 Uniform Assessment Tool 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, 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 was admitted on December 23, 2018.	01620			

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01620	Continued From page 43 R1's Service Plan Modification dated November 24, 2023, indicated R1 received nursing monitoring for medications, coordination with pharmacy for delivery of medications, and nursing assessment with a reassessment schedule of 90 days and as change in condition. On March 19, 2024, at 1:28 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C provided three (3) assessments dated December 1, 2021, December 1, 2022, and December 1, 2023, for R1 and stated they were R1's last three consecutive assessments. The assessments each lacked to address the following required content per Minnesota Administrative Rule 4659.0150 Uniform Assessment: - side rails in place to aid R1 for bed mobility; - a review of all medications R1 was administered or prescribed to include - (a) the reason taken; - (b) any side effects, contraindications, allergic or adverse reactions, and actions to address these issues; - (c) the dosage; - (d) the frequency of use; - (e) the route administered or taken; - (f) any difficulties the resident faces in taking the medication; - (g) whether the resident self administers the medication; - (h) the resident's preferences in how to take medication; - who has decision-making authority for the resident, including: - the presence of any advance health care directive or other legal document that establishes a substitute decision maker; and	01620			

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01620	Continued From page 44 - the scope of decision-making authority of a substitute decision maker. On March 20, 2024, at 8:30 a.m., LALD/CNS-C stated licensee had a history of providing services within the foster care system which only required an annual review and licensee had only completed annual assessments for all residents who received cares. LALD/CNS-C stated licensee was not aware of the 90-day assessment requirement and the content requirements per Minnesota Administrative Rule 4659.0150 Uniform Assessment Tool. LALD/CNS-C stated licensee had all required policies and procedures for assisted living but had implemented the processes of foster care and not assisted living. The licensee's 6.02 Assessment Schedules policy dated July 1, 2021, indicated ongoing assessments would be completed, "As needed based on changes in the needs of the resident but cannot exceed 90 calendar days from the last date of the assessment." The licensee's 6.03 Uniform Assessment Tool policy dated July 1, 2021, indicated all required content per Minnesota Administrative Rule 4659.0150 Uniform Assessment Tool and included a Uniform Assessment Tool sample form with all required content. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01620			
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan	01730			

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01730	Continued From page 45 (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 46 medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an individualized medication management record with the required content 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, 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 was admitted on December 23, 2018. R1's Service Plan Modification dated November 24, 2023, indicated R1 received nursing monitoring for medications, coordination with pharmacy for delivery of medications, and nursing assessments. On March 20, 2024, at 8:00 a.m., observed unlicensed personnel (ULP)-A obtain R1's medications from a medication cart in licensee's kitchen area. ULP-A stated all resident medications are stored in the medication cart to prevent others from accessing medications. R1's medication management record lacked a description of storage of medications based on the resident's needs and preferences, risk of	01730			

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01730	Continued From page 47 diversion, and consistent with the manufacturer's directions. On March 21, 2024, at 12:00 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated licensee was not aware of all required content for a medication management record. LALD/CNS-C stated licensee stored all medications in the medication cart in licensee's kitchen to prevent access to medications by an unauthorized person but had not included the requirement in each resident's medication management record. The licensee's 7.03 Medications Management Individualized Plan policy dated January 1, 2022, indicated each residents' medication management record would have included, "a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730			
01760 SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the	01760			

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01760	Continued From page 48 reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medication administration was documented accurately for one of 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, 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 was admitted on December 23, 2018. R1's Service Plan Modification dated November 24, 2023, indicated R1 received nursing monitoring for medications, coordination with pharmacy for delivery of medications, and nursing assessments. On March 20, 2024, at 8:00 a.m., observed unlicensed personnel (ULP)-A obtain and administer R1's medications from a medication cart in licensee's kitchen area. After ULP-A provided medications to R1, ULP-A documented the administration in R1's medication	01760			

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01760	Continued From page 49 administration record (MAR). R1's MAR dated March 2024, lacked documentation of administration or refusal of medications for the following dates and times: March 1, 2024, at 8:00 p.m., for duloxetine capsule 10 milligrams (mg), fluticasone 220 microgram (mcg) inhaler, mirtazapine tablet 30 mg, and tamsulosin capsule 0.4 mg; March 3 and 4, 2024, at 5:00 p.m., for senexon-s tablet 8.6-50 mg; March 11 and 12, 2024, at 8:00 p.m., for tamsulosin capsule 0.4 mg. On March 21, 2024, at 12:00 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated licensee was not aware R1's medications were not documented as administered. LALD/CNS-C stated ULPs had not contacted LALD/CNS-C to inform them R1's medications were not administered as required per licensee's policy. LALD/CNS-C stated ULP most likely had administered the medications but failed to document the administration as R1's medication count was accurate and did not reflect a missed administration. The licensee's 7.22 Medication & Treatment Record - Documentation & Refusal policy dated January 1, 2022, indicated all administered medications would be documented on each resident's MAR and if medication was refused, the registered nurse or licensed health professional would be contact for direction and would be documented in each resident's record. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			

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01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were stored securely for one of one resident (R1) with 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, 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 was admitted on December 23, 2018. R1's Service Plan Modification dated November 24, 2023, indicated R1 received nursing monitoring for medications, coordination with pharmacy for delivery of medications, and nursing assessments. On March 20, 2024, at 8:00 a.m., observed unlicensed personnel (ULP)-A obtain and administer R1's medications from a medication cart stored in licensee's common kitchen area. The medication cart had a lock on the outside of	01880			

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01880	Continued From page 51 the cart and inside the cart was a lockbox identified by ULP-A as licensee's controlled medication double lock process. ULP-A stated all resident medications are stored in the common medication cart. On March 20, 2024, at 12:03 p.m., during continuous observations, ULP-A left the kitchen area to assist R1 in R1's bedroom. Medication cart lock was left unlocked while a resident was sitting in the common living room area. No other employees were working in the facility. Surveyor was able to open medication cart and access all medications which included the controlled medication lock box. ULP-A returned to the kitchen at 12:09 p.m. ULP-A stated medication cart should have been locked to ensure unauthorized persons were not able to access medications. On March 21, 2024, at 12:00 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated licensee's expectations were the medication cart was to be secured and locked at all times unless an employee was required to access medications. LALD/CNS-C stated staff would be reminded of the requirement and licensee would review licensee's policy and procedure with all employees. The licensee's 7.11 Medications Storage policy dated January 1, 2022, indicated all medications would be securely locked in a medication cart when stored in a common area of the facility. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34050	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/21/2024
NAME OF PROVIDER OR SUPPLIER TRANQUIL LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 2521 WILSHIRE BOULEVARD MOUND, MN 55364			
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01940	Continued From page 52	01940			
01940 SS=F	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a treatment or therapy management plan to include	01940			

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01940	Continued From page 53 all required content for one of one resident with a treatment (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: R1 was admitted on December 23, 2018, with diagnosis which included obstructive sleep apnea (OSA, a disease which stops a person from breathing at night), enlarged prostate, acute chronic congestive heart failure (a disease where the body is unable to effectively pump blood through the body), and diabetes mellitus type two. R1's Service Plan Modification dated November 24, 2023, failed to identify treatments provided by licensee and ordered by a licensed health professional. R1's Home Health Certification and Plan of Treatment dated March 8, 2024, identified by licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C as R1's current treatment orders read, "Teds (thromboembolic deterrent stockings) or ace wrap on am and off pm," and "CPAP (continuous positive airway pressure, a machine used to keep airways open while sleeping) on HS (hour of sleep) off in AM. Check and Refill humidifier water daily." R1's Treatment Administration Record (TAR) dated March 2024, indicated the entire month of	01940			

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01940	Continued From page 54 March, licensee had performed putting on and taking off R1's TED hose and CPAP at the scheduled times. On March 21, 2024, at 12:00 p.m., LALD/CNS-C stated licensee was not aware treatments provided were required to be listed on the resident's service plan. LALD/CNS-C stated licensee had provided the services as ordered by R1's health care provided but had not updated R1's service plan to reflect the treatments provided. The licensee's 7.05 Treatment & Therapy Management Plan policy dated January 1, 2022, indicated licensee would prepare and include on the resident's service plan all treatment and therapy provided to each resident. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01940			
02310 SS=I	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 provide care and services according to acceptable health care, medical, or nursing standards for one of one	02310			

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02310	Continued From page 55 resident (R1) with bed rails. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 was admitted on December 23, 2018, with diagnoses of neurocognitive disorder due to traumatic brain injury (TBI), Diabetes Mellites type 2, left sided weakness, and vertigo (spinning sensation). R1's Home Health Certification and Plan of Treatment signed by R1's primary care provider on March 8, 2024, indicated R1 required grab bars (common term interchanged for bed rails) for safety measures related to R1's risk for falls. R1's undated Metro Health Care Services Side-Rail Use Assessment Form indicated R1 used bilateral (both sides) side rails to promote independence. The assessment lacked measurements, lacked indication if the side rails were Food and Drug Administration (FDA) compliant, and lacked notation risk verses benefits were discussed with the resident or responsible party. On March 19, 2024, at 10:20 a.m., during a tour, R1's bed was noted to have hospital style bedrails attached bilaterally. Bed rails were grabbed by surveyor and bed rails appeared to be secured	02310			

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02310	Continued From page 56 well to bed with minimal movement when surveyor pushed and pulled on them. On March 20, 2023, at 7:30 a.m., observed R1 getting out of bed on own without assistance. R1 placed their weight on the bedrails to aid in getting out bed. R1 stated they needed the bed rails as R1 would not be able to pull themselves upright to stand without the aid of the bed rails. On March 20, 2024, at 8:30 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated during a phone call licensee was not aware of all the requirements for bed rails. LALD/CNS-C stated licensee had not completed measurements, ensured the bed rails were FDA compliant, discussed risk versus benefits with the resident, and documented those actions and responses. The Food and Drug Administration's (FDA), A Guide to Bed Safety, revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." On page 21, Table 3 Summary of FDA Hospital Bed Dimensional Limit Recommendations indicated specific measurement limits for each entrapment zone. The licensee's 6.28 Side rails policy dated July 1,	02310			

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02310	Continued From page 57 2021, indicated licensee would ensure rails were FDA compliant, measurements were within the FDA's guidelines, and risk versus benefits would be discussed and documented in the resident's record. The Minnesota Department of Health's (MDH) Assisted Living: Resources and Frequently-Asked Questions (FAQs) website accessed on March 20, 2023, at 9:33 a.m., read under Hospital-style bed rails licensees should ensure, "measurements were completed and documented, the rails were FDA compliant, and the risk versus benefits were discussed and documented with the resident/responsible party." TIME PERIOD FOR CORRECTION: Immediate The immediacy of order 2310 was removed on March 21, 2024, at 6:20 p.m. The scope and level remain unchanged.	02310			
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the required notice was posted at the main entry way of the facility to display statutory language to disclose electronic	03090			

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03090	Continued From page 58 monitoring activity. This had the potential to affect the current residents, staff, and any visitors of the licensee. 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: On March 19, 2024, at 9:45 a.m., the surveyor arrived at the licensee's facility and noted no electronic monitoring notice was posted at the main entrance of the facility. On March 19, 2024, at 10:20 a.m., during a tour of the facility, unlicensed personnel (ULP)-A stated no electronic monitoring signage was posted as ULP-A was not aware a sign was required to be posted. On March 21, 2024, at 12:00 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated licensee was not aware the required verbatim language for electronic monitoring was required to be posted at the main entrance. LALD/CNS-C stated a sign would need to be created and posted at the main entrance. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090			

Type: Full
Date: 03/19/24
Time: 19:00:00
Report: 8041241044

Food and Beverage Establishment Inspection Report

Page 1

Location:

Tranquil Living
2521 Wilshire Boulevard
Mound, MN55364
Hennepin County, 27

Establishment Info:

ID #: 0038194
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6126159749
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.

2-200 Employee Health

2-201.11C

**** Priority 1 ****

MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority at the specific request of the regulatory authority.

FACILITY DOES NOT HAVE AN EMPLOYEE ILLNESS LOG. MDH LOG FORM SENT WITH REPORT. EXCLUSION AND LOGGING REQUIREMENTS REVIEWED.

Comply By: 03/19/24

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

3-302.11A(1)

**** Priority 1 ****

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

UNPASTAURIZED SHELL EGGS STORED ABOVE READY-TO-EAT FOODS IN THE REFRIGERATOR. CORRECTED ON SITE. EGGS WERE MOVED TO THE BOTTOM SHELF DURING INSPECTION.

Comply By: 03/19/24

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.

NO TEMPERATURE INDICATOR ON SITE TO MEASURE THE UTENSIL SURFACE TEMPERATURE FOR THE DISH MACHINE. THERMAL LABEL PROVIDED FOR ESTABLISHMENT TO TEST DISH MACHINE.

Comply By: 04/02/24

Type: Full
Date: 03/19/24
Time: 19:00:00
Report: 8041241044
Tranquil Living

Food and Beverage Establishment Inspection Report

Page 2

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.
FACILITY DOES NOT HAVE A CFPM. MANAGER RECENTLY TOOK FOOD SAFETY CLASS.
SUBMIT INITIAL CFPM APPLICATION TO MDH.

Comply By: 04/19/24

4-200 Equipment Design and Construction

4-204.112A

MN Rule 4626.0620A Provide a temperature measuring device located in the warmest part of mechanically refrigerated units and coolest part of hot food storage units that are capable of measuring air temperature or a simulated product temperature.

HOT POINT REFRIGERATOR IN THE KITCHEN DOES NOT HAVE A THERMOMETER INSIDE.

Comply By: 03/26/24

6-300 Physical Facility Numbers and Capacities

6-301.14A

MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands

NO HANDWASHING SIGN OR POSTER AT THE KITCHEN HAND SINK.

Comply By: 03/26/24

Food and Equipment Temperatures

Process/Item: Cold Holding

Temperature: 41 Degrees Fahrenheit - Location: hot point refrigerator: milk

Violation Issued: No

Process/Item: Cold Holding

Temperature: 41 Degrees Fahrenheit - Location: samsung refrigerator: ham

Violation Issued: No

Process/Item: Cold Holding

Temperature: 41 Degrees Fahrenheit - Location: samsung refrigerator: feta

Violation Issued: No

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

Inspection was completed with Phong Bui and also reviewed by phone with the food service manager of facility, Kimloan Sloss. Brandon Mueller was the lead Health Regulation Division Nurse Evaluator. Facility had four residents on site at time of inspection. Meals are prepared on site by staff.

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 and wood flooring. All found to be in good condition.

Establishment has a one basin sink that must be used for handwashing only. The Maytag dish machine was tested using thermal strip and had a utensil surface temperature of at least 160F.

Type: Full
Date: 03/19/24
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Food and Beverage Establishment Inspection Report

Page 3

Discussed the following:

- Employee illness policy and logging requirements
- Handwashing
- Glove-use and bare hand contact
- Food storage and preventing cross contamination
- Date marking
- Vomit clean up procedures
- Thermometer calibration
- Restrictions concerning serving a highly susceptible population

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

I acknowledge receipt of the Minnesota Department of Health inspection report
number 8041241044 of 03/19/24.

Certified Food Protection Manager: _____

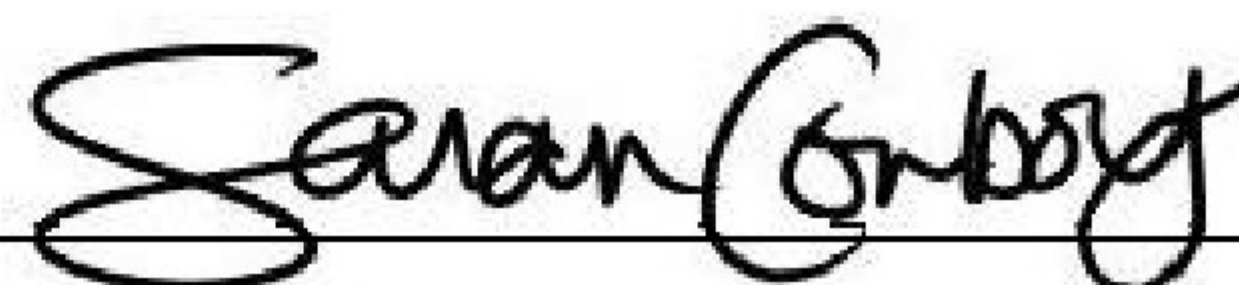
Certification Number: _____ Expires: ____ / ____ / ____

Inspection report reviewed with person in charge and emailed.

Signed: _____

Kimloan Sloss
Food Manager

Signed: _____



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