Electronically delivered

June 17, 2022

Administrator
Paradise Assisted Living, Inc.
10829 Vincent Avenue South
Bloomington, MN 55431

RE: Project Number(s) SL34760015

Dear Administrator:

On June 10, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine correction of orders found on the evaluation completed on January 19, 2022. The follow-up evaluation determined your facility had not corrected all of the state licensing orders issued pursuant to the January 19, 2022 evaluation.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state licensing orders issued pursuant to the last evaluation completed on January 19, 2022, found not corrected at the time of the June 10, 2022, follow-up evaluation and/or subject to penalty assessment are as follows:

0680-Disaster Planning And Emergency Preparedness-144g.42 Subd. 10 = $500.00

The details of the violations noted at the time of this follow-up evaluation completed on June 10, 2022 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $500.00**. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), by the correction order date, the licensee must document in the provider's records any action taken to comply with the correction order by the correction order date. The commissioner may request a copy of this documentation and the assisted living facility's action to respond to the correction orders in future evaluations, upon a complaint investigation, and as otherwise needed.

IMPOSITION OF FINES:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in §144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism

authorized in §144G.20.

Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in §144G.20.

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you have one opportunity to challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. This written request must be received by the Department of Health within 15 calendar days of the correction order receipt date. Please send your written request via email to the following:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970
Health.HRD.Appeals@state.mn.us

REQUESTING A HEARING

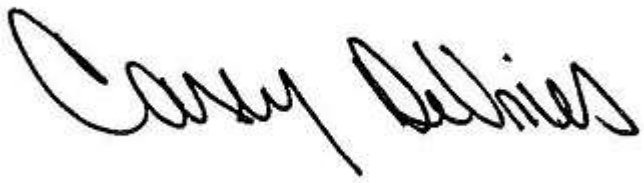
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for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

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both.

We urge you to review these orders carefully. If you have questions, please contact Casey DeVries at 651-201-5917.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Sincerely,



Casey DeVries, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-5917 Fax: 651-215-9697

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34760	A. BUILDING: _____ B. WING _____	R 06/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARADISE ASSISTED LIVING INC	10829 VINCENT AVENUE SOUTH BLOOMINGTON, MN 55431

(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 *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL34760015-2 On June 9, 2022, through June 10, 2022, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on April 5, 2022. At the time of the survey, there were 2 residents receiving services under the Assisted Living license. As a result of the revisit, the following orders were reissued.	{0 000}	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	{0 480}		

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{0 480}	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: No further action required.	{0 480}		
{0 680} 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	{0 680}		

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{0 680}	Continued From page 2 (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness plan (EPP) with all required content. 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: The licensee's EPP lacked the following required content: - all hazards-based emergency preparedness program with a risk assessment considering all hazards that may impact all or a portion of the facility; - emergency program patient population; and	{0 680}		

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{0 680}	Continued From page 3 - emergency prep testing requirements. On June 10, 2022, at 8:45 a.m., human resources (HR)-B verified the EPP lacked the above content. HR-B stated the licensee had recently discussed other hazards and vulnerabilities the EPP lacked, and the licensee would update the EPP for certain situations the facility may experience. In addition, HR-B stated the licensee lacked knowledge for the emergency prep testing requirements. The licensee's undated Emergency Management policy indicated the licensee will develop and maintain a written emergency management plan describing the process for disaster readiness and emergency management to ensure safety of its residents and employees during periods of an emergency or disaster that disrupts the licensee's services. No further information was provided.	{0 680}		
{0 780} SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but	{0 780}		

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{0 780}	Continued From page 4 not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: No further action required.	{0 780}		
{0 790} SS=F	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: No further action required.	{0 790}		
{0 800} SS=E	144G.45 Subd. 2 (a) (4) Fire protection and physical environment	{0 800}		

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{0 800}	Continued From page 5 (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: No further action required.	{0 800}		
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The	{0 810}		

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{0 810}	Continued From page 6 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: No further action required.	{0 810}		
{0 940} SS=C	144G.50 Subd. 2 Contract information (5) a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: (i) whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; (ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); (iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; (iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; (v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent;	{0 940}		

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{0 940}	Continued From page 7 (vi) a statement that residents may be eligible for assistance with rent through the housing support program; and (vii) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; (6) the contact information to obtain long-term care consulting services under section 256B.0911; and (7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written assisted living contract with all required content for two of two residents (R2, R3) with records reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2 admitted for service on April 9, 2020. R3 admitted for service on April 21, 2022. R2 and R3's record included a Resident Contract for Assisted Living signed March 3, 2022, and April 21, 2022, respectively. R2 and R3's contract lacked whether there was a limit on the number of people residing at the facility who can	{0 940}		

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{0 940}	Continued From page 8 receive customized living services or participate in the housing support program at any point in time. On June 10, 2022, at approximately 8:54 a.m., licensed assisted living director (LALD)-D verified the contract lacked the above content. In addition, LALD-D stated the licensee misunderstood the statute requirement. The licensee's undated Assisted Living Contracts policy indicated the contract would include whether there was a limit on the number of people residing at the licensee who can receive customized living services or participate in the housing support program, and if so, the limit must be specified. No further information was provided.	{0 940}		
{01530} SS=D	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial	{01530}		

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{01530}	Continued From page 9 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 all staff received eight hours of initial dementia care training within the first 120 working hours of employment for supervisors of direct care staff as required for one of four employees (registered nurse (RN)-A) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: RN-A started employment on March 17, 2020, under the comprehensive home care license and began providing assisted living services on August 1, 2021. RN-A's My Transcript included dementia training courses completed between May 15, 2020, and	{01530}		

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{01530}	Continued From page 10 February 14, 2022, to include a total of seven and a half (7.5) hours of dementia training. My Transcript also included one hour 15 minutes (1.25 hours) of dementia training completed June 9, 2022, that occurred while the survey was in progress. On June 9, 2022, at 3:39 p.m., human resources (HR)-B and licensed assisted living director (LALD)-D verified RN-A, lacked the required eight (8) hours of dementia care training within the required time frame. HR-B stated RN-A was assigned to complete 3 electronic modules on dementia and did not know the reason why RN-A did not complete the modules. The licensee's undated Dementia Care Training policy indicated supervisors of direct care staff must have eight (8) hours of initial dementia care training within the first 120 working hours of employment. No further information was provided.	{01530}		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

April 27, 2022

Administrator
Paradise Assisted Living, Inc.
10829 Vincent Avenue South
Bloomington, MN 55431

RE: Project Number(s) SL34760015

Dear Administrator:

On April 5, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine correction of orders found on the evaluation completed on January 19, 2022. The follow-up evaluation determined your agency had not corrected all of the state licensing orders issued pursuant to the January 19, 2022 evaluation.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state licensing orders issued pursuant to the last evaluation completed on January 19, 2022, found not corrected at the time of the April 5, 2022, follow-up evaluation and/or subject to penalty assessment are as follows:

0485-Minimum Requirements-144g.41 Subd 1. (13) (i) (a) And (c) = $500.00
0580-Quality Management-144g.42 Subd. 2 = $500.00
0650-Employee Records-144g.42 Subd. 8 = $500.00
0680-Disaster Planning And Emergency Preparedness-144g.42 Subd. 10 = $500.00
0950-Designation Of Representative-144g.50 Subd. 3 = $500.00
1470-Content Of Required Orientation-144g.63 Subd. 2 = $500.00
1620-Initial Reviews, Assessments, And Monitoring-144g.70 Subd. 2 (c-E) = $500.00
1650-Service Plan, Implementation And Revisions To-144g.70 Subd. 4 (f) = $500.00

The details of the violations noted at the time of this follow-up evaluation completed on April 5, 2022 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $4,000.00**. You will be invoiced after 15 days of the receipt of this notice, subject to appeal. **OR** Also, at the time of this follow-up evaluation completed on April 5, 2022, we identified the following violation(s):

0940-Contract Information-144g.50 Subd. 2
1530-Training In Dementia Care Required-144g.64

The details of the violation(s) noted at the time of this follow-up evaluation are delineated on the attached State Form. Only the ID Prefix Tag in the left hand column without brackets will identify these licensing orders. It is not necessary to develop a plan of correction.

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), by the correction order date, the licensee must document in the provider's records any action taken to comply with the correction order by the correction order date. The commissioner may request a copy of this documentation and the assisted living facility's action to respond to the correction orders in future evaluations, upon a complaint investigation, and as otherwise needed.

IMPOSITION OF FINES:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in §144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in §144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in §144G.20.

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you have one opportunity to challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. This written request must be received by the Department of Health within 15 calendar days of the correction order receipt date. Please send your written request via email to the following:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970
Health.HRD.Appeals@state.mn.us

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. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you

may request a reconsideration **or** a hearing, but not both.

We urge you to review these orders carefully. If you have questions, please contact Jess Gallmeier at 651-247-0268.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Sincerely,

Jess Gallmeier, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-247-0268 Fax: 651-215-9697

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34760	A. BUILDING: _____ B. WING _____	R 04/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARADISE ASSISTED LIVING INC	10829 VINCENT AVENUE SOUTH BLOOMINGTON, MN 55431

(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 *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: Project # SL34760015-1 On April 5, 2022, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on January 19, 2022. At the time of the survey, there was one resident receiving services under the Assisted Living license. As a result of the revisit, the following orders were reissued.	{0 000}	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	{0 480}		

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{0 480}	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (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 included document titled, Food and Beverage Establishment Inspection Report dated April 5, 2022, for the specific Minnesota Food Code deficiencies.	{0 480}		

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{0 480}	Continued From page 2 No further information was provided.	{0 480}		
{0 485} SS=F	144G.41 Subd 1. (13) (i) (A) and (C) Minimum Requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (A) menus must be prepared at least one week in advance, and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; (C) the facility cannot require a resident to include and pay for meals in their contract; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure meals were nutritious or in accordance with United States Department of Agriculture (USDA) guidelines. In addition, the licensee failed to ensure a menu was prepared a week in advance and made available to the resident. This practice resulted in a level two violation (a	{0 485}		

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{0 485}	Continued From page 3 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On April 5, 2022, at approximately 9:40 a.m., the surveyor observed a meal menu posted on bulletin board in the common area. The posted meal menu lacked food from each group as recommended in the Meal and Menu Requirements - MyPlate: A Guide USDA guideline, in each serving to include a fruit, a vegetable, a protein, a grain and dairy. In addition, the menu posted was for one week starting April 4, 2022 through April 10, 2022. On April 5, 2022, at approximately 10:29 a.m., licensed assisted living director (LALD)-D stated the food listed on meal menu post was what was provided to the resident. In addition, LALD-D stated additional food items are not provided unless requested by resident. LALD-D acknowledged meal menu was not nutritious and did not follow the USDA guidelines. LALD-D confirmed the meal menu was not posted one week in advance and made available to the resident. LALD-D stated the licensee was not aware of a week in advance menu requirement. The licensee lacked a policy on menu planning and meal service. No further information was provided.	{0 485}		

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{0 580}	Continued From page 4	{0 580}		
{0 580} SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to implement and maintain a quality management program (QMP) appropriate to the size of the facility and relevant to the type of services provided. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: On April 5, 2022, at approximately 10:35 a.m., licensed assisted living director (LALD)-D provided surveyors with a document titled	{0 580}		

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{0 580}	Continued From page 5 Paradise Assisted Living Quality Management Plan January-June 2022, identifying two goals and meeting frequency for the period: - monitoring home health aide (HHA) communication with registered nurse on urgent matters with a weekly meeting frequency; and - monitor resident complaints with a monthly meeting frequency. On April 5, 2022, at approximately 10:39 a.m., they surveyor requested the QMP minutes. LALD-D stated they had not started having QMP meetings. In addition, LALD-D stated they have created a QMP but have not implemented program. The licensee's undated Quality Management Program policy, stated the facility would develop a continuous quality management program to identify, support, and maintain the facility's quality improvement efforts and provide quality services to its residents. The policy indicated outcome measurements from quality management activities would be monitored and reports would be retained in the facility for two (2) years and made available to the Minnesota Department of Health upon request. No further information provided.	{0 580}		
{0 630} SS=E	144G.42 Subd. 6 Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the	{0 630}		

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{0 630}	Continued From page 6 person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for one of one resident (R2) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2 was admitted to the licensee on April 9, 2020. R2's diagnoses included mood disorder, opiate dependence, and borderline personality disorder. R2's service plan dated February 19, 2022, indicated R2 received comprehensive assessments, bathing, dressing, transfer, medication reminders, laundry, shopping, meal prep, mental health management, and non medical transportation. R2's Home Health Aide Care Plan dated February 10, 2022, indicated R2 had problems to include: - manage behaviors each shift including anxiety,	{0 630}		

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{0 630}	Continued From page 7 agitation, mood swings; - remind resident of appointments due to forgetfulness sometimes; and - suicidal thoughts. R2's IAPP dated February 2022, indicated R2 was susceptible to mental health abuse but did not identify specific measures to minimize the risk of abuse. In addition, the IAPP did not include susceptibilities identified in the Home Health Aide Care Plan dated February 10, 2022, and statements of the specific measures to be taken to minimize the risk of abuse to R2 and other vulnerable adults On April 5, 2022, at approximately 11:40 a.m., licensed assisted living director (LALD)-D acknowledged R2's IAPP did not include statements of the specific measures to be taken to minimize the risk of abuse to R2 and other vulnerable adults. The licensee's undated Abuse Prevention Plan policy indicated all residents admitted to the licensee would be assessed for their susceptibility to abuse by other individuals, including other vulnerable adults and their risk of abusing other vulnerable adults. The policy indicated a statement of the specific measures that will be taken to minimize the risk of abuse would be developed. The policy indicated the plan would be reviewed as necessary and adjusted to respond to the resident's needs. No further information was provided.	{0 630}		
{0 650} SS=E	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of	{0 650}		

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{0 650}	Continued From page 8 each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure current employee records were maintained to include all required content for two of two employees (registered nurse (RN)-A, unlicensed personnel (ULP)-E) with records reviewed.	{0 650}		

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{0 650}	Continued From page 9 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: RN-A RN-A started employment on March 17, 2020, under the comprehensive home care license and began providing assisted living services on August 1, 2021. RN-A's employee file lacked the following required content: - a job description; and - annual performance reviews that identify areas of improvement needed and training needs. ULP-E ULP-E started employment on March 8, 2021, under the comprehensive home care license and began providing assisted living services on August 1, 2021. ULP-E's employee file lacked the following required content: - documentation of annual performance reviews that identify areas of improvement needed and training needs. On April 5, 2022, at approximately 12:39 p.m., licensed assisted living director (LALD)-D acknowledged RN-A and ULP-E's employee	{0 650}		

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{0 650}	Continued From page 10 records were missing the above required content. The licensee's undated Job Description policy indicated a job description will be signed by the employee and placed in their personnel file. The licensee's undated Performance Evaluations policy indicated a competency-based performance evaluation will be conducted for all employees yearly. No further information was provided.	{0 650}		
{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 tenant 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	{0 680}		

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{0 680}	Continued From page 11	{0 680}		

working on site.
(c) The facility must meet any additional requirements adopted in rule.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to have a written emergency disaster preparedness plan with all required content. This had the potential to affect the licensee's resident, 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 April 5, 2022, at approximately 10:38 a.m., the surveyor requested to view the licensee's emergency preparedness plan (EPP).

The licensee's EPP lacked the following required content:
-all hazards-based emergency preparedness program with a risk assessment considering all hazards that may impact all or a portion of the facility;
-an assessment of the at-risk population's needs;
-a process for emergency preparedness (EPS) cooperation with state and local EP officials/organizations;
-policies and procedures that are stored in a central place;

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{0 680}	Continued From page 12 -subsistence needs for staff and residents during emergency situation; -procedure for tracking staff and residents; -development of all policies and procedures, based on risk assessment, and additional policies individualized to the facility for: potential evacuation, sheltering in place, handling medical documents and how the facility will provide care under an 1135 waiver declared by the Secretary; -a plan for sheltering in place when not able to evacuate; -transfer agreements and/or contracts with other facilities/providers to receive residents in the event of evacuation or other limitations that would impact the continuity of services; and -a communication plan with the following required content: names and contact information for staff/entities providing services under an agreement, residents' physicians, other facilities, volunteers, federal, state, tribal, regional, and local emergency preparedness staff, state licensing and certification agency, Office of the State Long Term Care Ombudsman, other sources of assistance, a plan for communicating during an emergency, including primary and alternative means for communication, procedures for sharing medical information to maintain continuity of care; and procedures for sharing the emergency plan with family members and residents. On April 5, 2022, at 10:38 a.m., licensed assisted living director (LALD)-D stated the licensee had not made any corrections to the EPP since the original survey. In addition, LALD-D stated the licensee had contacted the city for assistance on completing the EPP. The licensee's undated Emergency Management policy indicated the licensee will develop and	{0 680}		

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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
{0 680}	Continued From page 13 maintain a written emergency management plan describing the process for disaster readiness and emergency management to ensure safety of its residents and employees during periods of an emergency or disaster that disrupts the licensee's services. No further information was provided.	{0 680}		
{0 780} SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by:	{0 780}		

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{0 780}	Continued From page 14 No further action required.	{0 780}		
{0 790} SS=F	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: No further action required.	{0 790}		
{0 800} SS=E	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: No further action required.	{0 800}		
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and	{0 810}		

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{0 810}	Continued From page 15 physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: No further action required.	{0 810}		

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0 940	Continued From page 16	0 940		
0 940 SS=F	144G.50 Subd. 2 Contract information (5) a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: (i) whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; (ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); (iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; (iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; (v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; (vi) a statement that residents may be eligible for assistance with rent through the housing support program; and (vii) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; (6) the contact information to obtain long-term care consulting services under section 256B.0911; and (7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center.	0 940		

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0 940	Continued From page 17 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written assisted living contract with all required content for one of one resident (R2) with record reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2 was admitted on April 9, 2020. R2's record included a Resident Contract For Assisted Living signed March 3, 2022. R2's contract lacked the following content: -a description of the licensee's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: -whether the licensee is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; -whether the licensee has agreement to provide housing support under section 256I.04 subd. 2, paragraph (b) - statement the MA waivers provide payment for services but do not cover the cost of rent; -statement that residents may be eligible for assistance with rent through the housing support program; and -description of the rent requirements for people	0 940		

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0 940	Continued From page 18 who are eligible for MA waivers but who are not eligible for assistance through housing support program. On April 5, 2022, at approximately 12:11 p.m., licensed assisted living director (LALD)-D confirmed the contract lacked the above content. In addition, LALD-D stated this would be the contract for all residents admitted. The licensee's undated Assisted Living Contracts policy indicated the contract would include the following content: - whether the licensee is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; - whether the licensee has an agreement to provide housing support under section 2561.04, Subdivision 2, paragraph (b); - whether there is a limit on the number of people residing at the licensee who can receive customized living services or participate in the housing support program, and if so, the limit must be specified; - whether the licensee requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private pay is required; - a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; - a statement that residents may be eligible for assistance with rent through the housing support program; and - a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program.	0 940		

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0 940	Continued From page 19 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 940		
{0 950} SS=F	144.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative.	{0 950}		

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{0 950}	Continued From page 20 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract included designation of representatives in writing with the required statutory language for one of one resident (R2) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2 was admitted on April 9, 2020. R2's Resident Contract For Assisted Living signed March 3, 2022, lacked the opportunity to designate a representative and the verbatim "right to designate a representative for certain purposes" notice. On April 5, 2022, at 12:11 p.m., licensed assisted living director (LALD)-D stated this is the new contract that would be used for any new residents admitting. LALD-D confirmed the contract lacked designation of representatives in writing with the required statutory language. LALD-D stated they would work on adding the verbatim to the contract. The licensee's undated Assisted Living Contracts policy indicated the licensee must offer the resident the opportunity to identify a representative in writing on the contract and must	{0 950}		

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{0 950}	Continued From page 21 provide "right to designate a representative for certain purposes" notice on a document separate from the contract. No further information provided.	{0 950}		
{01470} SS=F	144G.63 Subd. 2 Content of required orientation (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	{01470}		

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{01470}	Continued From page 22 (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 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 all required content of orientation was provided to three of three employees (registered nurse (RN)-A, unlicensed personnel (ULP)-C, ULP-E) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	{01470}		

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{01470}	Continued From page 23 or has the potential to affect a large portion or all of the residents). The findings include: RN-A RN-A started employment on March 17, 2020, under the comprehensive home care license and began providing assisted living services on August 1, 2021. RN-A's Staff Orientation Outline and Sign-off dated March 17, 2020, indicated RN-A had completed: - orientation to home care requirements - overview of home care statutes - home care bill of rights - introduction and review of agency policies and procedures related to providing home care services ULP-C ULP-C started employment on August 28, 2020, under the comprehensive home care license and began providing assisted living services on August 1, 2021. ULP-C's Staff Orientation Outline and Sign-off dated March 17, 2020, indicated ULP-C had completed: - orientation to home care requirements - overview of home care statutes - home care bill of rights - introduction and review of agency policies and procedures related to providing home care services ULP-E ULP-E started employment on March 8, 2021, under the comprehensive home care license and	{01470}		

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{01470}	Continued From page 24 began providing assisted living services on August 1, 2021. ULP-E's Staff Orientation Outline and Sign-off dated March 8, 2021, indicated ULP-E had completed: - orientation to home care requirements - overview of home care statutes - home care bill of rights - introduction and review of agency policies and procedures related to providing home care services RN-A, ULP-C and ULP-E's employee records lacked evidence the employees received orientation on the new assisted living statute to include the following topics: - an overview of the assisted living statutes; - an introduction and review of the licensee's policies and procedures related to the provision of assisted living services by the individual staff person; - the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; and - a review of the types of assisted living services the employee will be providing and the licensee's category of licensure. On April 5, 2022, at approximately 11:35 a.m., licensed assisted living director (LALD)-D acknowledged RN-A, ULP-C, and ULP-E's employee records were missing the required orientation content identified above. In addition, LALD-D stated all employee records would be missing the same content above.	{01470}		

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{01470}	Continued From page 25 The licensee's undated Facility Employee Orientation policy indicated employees would complete an orientation on topics required by Minnesota statutes and rules for assisted living. No further information was provided.	{01470}		
01530	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be 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	01530		

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01530	Continued From page 26 by: Based on interview and record review, the licensee failed to ensure all staff received eight hours of initial dementia care training within the first 120 working hours of employment for supervisors of direct care staff and within the first 160 working hours of employment for direct care employees as required for three of three employees (registered nurse (RN)-A, unlicensed personnel (ULP)-C, ULP-E) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: RN-A RN-A started employment on March 17, 2020, under the comprehensive home care license and began providing assisted living services on August 1, 2021. RN-A's My Transcript included dementia training courses completed between May 15, 2020 and February 14, 2022, to include a total of seven and a half (7.5) hours of dementia training. ULP-C ULP-C started employment on September 14, 2020, under the comprehensive home care license and began providing assisted living services on August 1, 2021.	01530		

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01530	Continued From page 27 ULP-C's My Transcript included dementia training courses completed between September 12, 2020 and February 23, 2022, to include a total of seven and a half (7.5) hours of dementia training. ULP-E ULP-E started employment on March 8, 2021, under the comprehensive home care license and began providing assisted living services on August 1, 2021. ULP-E's My Transcript included dementia training courses completed between March 8, 2021 and February 25, 2022, to include a total of six (6) hours and forty-five (45) minutes of dementia training. On April 5, 2022, at 1:45 p.m., licensed assisted living director (LALD)-D acknowledged RN-A, ULP-C, and ULP-E lacked the required eight (8) hours of dementia care training within the required time frame. The licensee's undated Dementia Care Training policy indicated supervisors of direct care staff must have eight (8) hours of initial dementia care training within the first 120 working hours of employment and direct care employees must have eight (8) hours of initial dementia care training within the first 160 hours of employment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01530		
{01620} SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring	{01620}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34760	A. BUILDING: _____ B. WING _____	R 04/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARADISE ASSISTED LIVING INC	10829 VINCENT AVENUE SOUTH BLOOMINGTON, MN 55431

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{01620}	Continued From page 28	{01620}		

(c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment.
(d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review.
(e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to ensure the registered nurse completed a comprehensive reassessment using the uniform assessment tool for one of one resident (R2) as required with record reviewed.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), 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

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{01620}	Continued From page 29 of the residents). The findings include: R2 was admitted to the licensee on April 9, 2020. R2's diagnoses included mood disorder, opiate dependence, and borderline personality disorder. R2's service plan dated February 19, 2022, indicated R2 received comprehensive assessments, bathing, dressing, transfer, medication reminders, laundry, shopping, meal prep, mental health management, and non medical transportation. R2's 90-Day Home Care Reassessment - Non skilled care dated February 16, 2022, lacked the required content for the Uniform Assessment Tool to iclude: - the residents personal lifestyle preferences; - activities of daily living; - instrumental activities of daily living; - physical health status; - emotional and mental health conditions or medications; - cognition; - communication and sensory capabilities; - nutritional and hydration status preferences; - list of treatments; - nursing needs, including potential to receive nursing-delegated services; - risk indicators; and - who has decision-making authority for the resident. On April 5, 2022, at approximately 11:10 a.m., licensed assisted living director (LALD)-D acknowledged the assessment tool used by the licensee did not contain all of the required content.	{01620}		

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{01620}	Continued From page 30 The licensee's undated Nursing Assessment and Reassessment of Residents policy indicated resident reassessment and monitoring would be conducted to meet the resident's needs and reflect person centered planning and care delivery. The policy also indicated the assessment would include but not limited to the requirements outlined in the Minnesota Rules. No further information was provided.	{01620}		
{01650} SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency	{01650}		

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{01650}	Continued From page 31	{01650}		

medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to ensure the service plan included the required content for one of one resident (R2) with record reviewed.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).

The findings include:

R2 was admitted to the licensee on April 9, 2020.

R2's service plan dated February 19, 2022, indicated R2 received comprehensive assessments, bathing, dressing, transfer, medication reminders, laundry, shopping, meal prep, mental health management, and non medical transportation.

R2's service plan lacked the following required content:
- the fees for services; and
- methods of monitoring staff providing services.

On April 5, 2022, at approximately 11:20 a.m., licensed assisted living director (LALD)-D acknowledged the service plan was missing the

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{01650}	Continued From page 32 required content and stated the licensee will update the resident's service plan to include the content. The licensee's undated Service Plan policy indicated the missing content will be included in the resident service plan. No further information was provided.	{01650}		

Minnesota Department of Health
Environmental Health, FPLS
P.O Box 64975
St. Paul
651-201-4500

Type: Full
Date: *04/05/22*
Time: 11:07:26
Report: 8059221008

Food and Beverage Establishment Inspection Report

Location:
Paradise Assisted Living Inc
10829 Vincent Avenue South
Bloomington, MN55431
Hennepin County, 27

Establishment Info:
ID #: 0037501
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6124172373
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 previously issued on 01/19/22 have NOT been corrected.

3-500C Microbial Control: date marking

3-501.17B ** Priority 2 **

MN Rule 4626.0400B Mark the refrigerated, ready-to-eat, TCS food prepared and packaged in a processing plant and opened and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded. The date must not exceed the manufacturer's use-by-date.

ESTABLISHMENT WAS NOT DATE MARKING AT READY-TO-EAT TCS FOODS. A FACT SHEET WAS SENT TOTHE ESTABLISHMENT.

Issued on: 01/19/22 *Comply By: 01/19/22*

2-100 Supervision

2-102.12AMN

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

NO CERTIFIED FOOD PROTECTION MANAGER IS EMPLOYED. A FACT SHEET WAS SENT TO THE ESTABLISHMENT.

Issued on: 01/19/22 *Comply By: 02/19/22*

No NEW orders were issued during this inspection.

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

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 8059221008 of 04/05/22.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Inspection report reviewed with person in charge and emailed.

Signed:_____
Salma Gelle
Home Health Aid

Signed:_____
James Noyola
Sanitarian Supervisor
St. Paul
651-201-4929
health.foodlodging@state.mn.us

Electronically Delivered

February 15, 2022

Administrator
Paradise Assisted Living, Inc.
10829 Vincent Avenue South
Bloomington, MN 55431

RE: Project Number(s) SL34760015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on January 19, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health 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.

The enclosed State Form documents the state licensing orders. The Department of Health 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 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.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation

that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health 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 (a)(5)(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 evaluation:

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program = $500.00

The total amount you are assessed is $500.00. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up surveys. The licensee is not required to submit a plan of correction 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 issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the Department of Health within 15 calendar days of the correction order receipt date.

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general reconsideration requests to:	Free from Maltreatment reconsideration requests should addressed to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

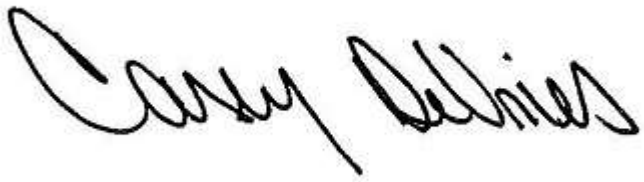
REQUESTING A HEARING

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

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,



Casey DeVries, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-5917 Fax: 651-215-9697

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 000	Initial Comments 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: SL34760015 On January 18, 2022, through January 19, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were three (3) residents receiving services under the provider's Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 110 SS=F	144G.10 Subdivision 1a Assisted living director license required	0 110		

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0 110	Continued From page 1 Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure licensed assisted living director (LALD)-D was listed as the Director of Record for the licensee. The licensee also failed to ensure a shared director plan was established and failed to ensure LALD-D's license was posted in a conspicuous place. This had the potential to affect all the licensee's residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On January 19, 2022, at approximately 11:00 a.m., human resources manager (HR)-B confirmed LALD-D had not completed a shared director application and the licensee had not established a shared director plan on how LALD-D would oversee two locations. HR-B confirmed LALD-D's license was not posted anywhere in the facility. HR-B confirmed LALD was not listed as the licensee's director of record.	0 110		

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0 110	Continued From page 2 The licensee lacked policies on a shared assisted living director or how they would designate the director of record. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
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	0 250		

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0 250	Continued From page 3 access according to section 256.9742, subdivision 4; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to 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 regulations. This has 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), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	0 250		

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PARADISE ASSISTED LIVING INC	10829 VINCENT AVENUE SOUTH BLOOMINGTON, MN 55431

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0 250	Continued From page 4 or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on January 18, 2022, at approximately 12:35 p.m., registered nurse (RN)-A confirmed the owner/licensed assisted living director (LALD)-D was responsible for and participated in the day-to-day operations. RN-A stated they were familiar with the Assisted Living licensing rules. The licensee attested they read and understood the Assisted Living licensing statutes and rules upon application; however, the following orders were issued: Refer to licensing order at Statute 144G.10 Subdivision 1a. The licensee failed to ensure LALD-D was listed as the Director of Record for the licensee. The licensee also failed to ensure a shared director plan was established and failed to ensure LALD-D's license was posted in a conspicuous place. Refer to licensing order at Statute 144G.40 Subd. 2. The licensee failed to provide a copy of the uniform checklist disclosure of services (UDALSA) with the required content for two of two residents (R1, R2) with records reviewed. Refer to licensing order at Statute 144G.41 Subdivision 1. The licensee failed to ensure the current Minnesota Bill of Rights for Assisted Living Residents was provided to the resident and a written acknowledgement received for two of two residents (R1, R2) with records reviewed. This had the potential to affect all residents.	0 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34760	A. BUILDING: _____ B. WING _____	01/19/2022

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0 250	Continued From page 5 Refer to licensing order at Statute 144G.41 Subdivision 1. The licensee failed to ensure food was prepared and served according to the Minnesota Food Code. Refer to licensing order at Statute 144G.41 Subdivision 1. The licensee failed to ensure to offer at least three nutritious meals daily, according to the recommended dietary allowances in the United Stated Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables, with records reviewed. The licensee also failed to post a menu a week in advance was made available to all residents. Refer to licensing order at Statute 144G.41 Subdivision 1. The licensee failed to have a daily program of social and recreational activities based on individual and group interests, physical, mental, and psychosocial needs. Refer to licensing order at Statute 144G.41 Subd. 3. The licensee failed to establish and maintain an effective infection control program that complied with accepted health care, medical and nursing standards for infection control related to COVID-19, when they did not comply with MDH guidance for COVID-19 related to wearing appropriate PPE (personal protective equipment) and having a testing plan. Refer to licensing order at Statute 144G.41 Subd. 7. The licensee failed to post the required information related to the grievance procedure and contact information for the Office of Ombudsman for Long-Term Care and Mental Health and Developmental Disabilities, as well as information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center	0 250		

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0 250	Continued From page 6 (MAARC). Refer to licensing order at Statute 144G.42 Subdivision 1. The licensee failed to display the original current license at the main entrance of the assisted living facility as required. Refer to licensing order at Statute 144G.42 Subd. 2. The licensee failed to implement and maintain a quality management program (QMP) appropriate to the size of the facility and relevant to the type of services provided. Refer to licensing order at Statute 144G.42 Subd. 6.(a) The licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) suspected maltreatment/self- neglect and complete a thorough investigation for two of two residents (R1, R2) with records reviewed. Refer to licensing order at Statute 144G.42 Subd. 6. The licensee failed to ensure an individual abuse prevention plan was developed to include the required content for two of two residents (R1, R2) with records reviewed. Refer to licensing order at Statute 144G.42 Subd. 7. The licensee failed to support protection and safety by not posting information and phone numbers for reporting to the Minnesota Adult Abuse Reporting Center (MAARC) and failed to post the 911 emergency number in common areas and near telephones provided by the assisted living facility. Refer to licensing order at Statute 144G.42 Subd. 8. The licensee failed to ensure current employee records were maintained to include all required content for two of four unlicensed personnel ((ULP)-D and ULP-E) with records reviewed.	0 250		

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0 250	Continued From page 7 Refer to licensing order at Statute 144G.42 Subd. 9. The licensee failed to ensure the provider established and maintained a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) current screening for active or latent TB for one of two employees (registered nurse (RN)-A). In addition, the licensee failed to ensure TB training was completed for one of two employees (unlicensed personnel (ULP)-C) with records reviewed. Refer to licensing order at Statute 144G.42 Subd. 10. The licensee failed to have a written emergency preparedness plan with all the required content as defined in Appendix Z, with records reviewed. Refer to licensing order at Statute 144G.45 Subd. 2. The licensee failed to provide interconnection of smoke alarms for resident bedrooms #1 and #2. Refer to licensing order at Statute 144G.45 Subd. 2. The licensee failed to maintain portable fire extinguishers in accordance with the State Fire Code as required. Refer to licensing order at Statute 144G.45 Subd. 2. The licensee failed to maintain the physical environment of the facility in a continuous state of good repair and operation. Refer to licensing order at Statute 144G.45 Subd. 2. The licensee failed to provide the required documentation on fire safety and evacuation plans, training, and evacuation drills. Refer to licensing order at Statute 144G.50	0 250		

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0 250	Continued From page 8 Subdivision 1. The licensee failed to develop and execute a written contract with the required content to provided assisted living services for two of two residents (R1, R2) with records reviewed. The licensee also failed to provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract. Refer to licensing order at Statute 144.50 Subd. 3. The licensee failed to offer two of two residents (R1, R2) the opportunity to identify a designated representative with records reviewed. Refer to licensing order at Statute 144G.60 Subdivision 1. The licensee failed to ensure a background study was completed as required for one of two employees (registered nurse (RN)-A) with records reviewed. Refer to licensing order at Statute 144G.61 Subd. 2. The licensee failed to ensure training and competency was completed for one of one employee (ULP-C), to include all required content with records reviewed. Refer to licensing order at Statute 144G.61 Subd. 2. The licensee failed to ensure training and competency was completed for one of one employee (ULP-C), to include all required content with records reviewed. Refer to licensing order at Statute 144G.62 Subd. 4. The licensee failed to ensure direct supervision of staff performing delegated tasks was provided within 30 calendar days after the date on which the individual begins working for the licensee for one of one unlicensed personnel (ULP-C) with records reviewed. Refer to licensing order at Statute 144G.63 Subd.	0 250		

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0 250	Continued From page 9 2. The licensee failed to ensure all required content of orientation was provided to two of two employees (RN-A and ULP-C) with records reviewed. Refer to licensing order at Statute 144G.63 Subd. 4. The licensee failed to ensure all staff received dementia care as required for two of two employees (RN-B and ULP-G) with records reviewed. Refer to licensing order at Statute 144G.63 Subd. 5. The licensee failed to ensure all employees had at least eight hours of annual training for each 12 months of employment that included the required content for two of two employees (RN-A and ULP-C) with records reviewed. Refer to licensing order at Statute 144G.70 Subd. 2. The licensee failed to ensure the RN completed a comprehensive reassessment using the uniform assessment tool on admission and day 14 for one of one resident (R1) and at day 90 for one of one resident (R2) as required with records reviewed. Refer to licensing order at Statute 144G.70 Subd. 4. The licensee failed to ensure the service plan included the required content for two of two residents (R1, R2) with records reviewed. Refer to licensing order at Statute 626.557 Subd. 3. The licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) suspected maltreatment/self-neglect and complete a thorough investigation for two of two residents (R1, R2) with records reviewed. Thirty-two (32) correction orders were issued, which indicated the licensee's understanding of	0 250		

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0 250	Continued From page 10 the Minnesota statutes and Rules were limited or not evident for compliance with sections 144G.08 to 144G.9999. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 250		
0 430 SS=C	144G.40 Subd. 2 Uniform checklist disclosure of services (a) All assisted living facilities must provide to prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a). This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide a copy of the uniform checklist disclosure of services (UDALSA) with the required content for two of	0 430		

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0 430	Continued From page 11 two residents (R1, R2) with records reviewed. This had the potential to affect all 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 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: R1's diagnoses included schizophrenia, anxiety, short term memory impairment, depression, and history of suicidal ideation. R1's service plan dated December 31, 2021, indicated R1 received comprehensive assessments as scheduled and safety checks each shift. R1's record indicated R1 received a copy of the Uniform Consumer Information Guide. R1's record lacked a uniform checklist disclosure of services to include: - a disclosure of the categories of assisted living licenses available and the category of license held by the facility; and - a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide. R2's diagnoses included mood disorder, opiate dependence, and borderline personality disorder.	0 430		

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0 430	Continued From page 12 R2's service plan, dated April 9, 2020, indicated R2 received comprehensive assessments as scheduled, personal care services, home management, and a daily safety check. R2's record indicated R2 received a copy of the Uniform Consumer Information Guide. R2's record lacked a uniform checklist disclosure of services to include: - a disclosure of the categories of assisted living licenses available and the category of license held by the facility; and - a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide. On January 18, 2022, at approximately 11:30 a.m., human resources manager (HR)-B stated the facility does have a UDALSA and a copy was provided to the surveyor. HR-B stated she was fairly sure the residents received a copy of it but confirmed she had no documentation to show it was received. The licensee lacked a policy regarding the uniform checklist disclosure of services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 430		
0 450 SS=C	144G.41 Subdivision 1 Minimum requirements	0 450		

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0 450	Continued From page 13 All assisted living facilities shall: (1) distribute to residents the assisted living bill of rights; (2) provide services in a manner that complies with the Nurse Practice Act in sections 148.171 to 148.285; (3) utilize a person-centered planning and service delivery process; (4) have and maintain a system for delegation of health care activities to unlicensed personnel by a registered nurse, including supervision and evaluation of the delegated activities as required by the Nurse Practice Act in sections 148.171 to 148.285; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the current Minnesota Bill of Rights for Assisted Living Residents was provided to the resident and a written acknowledgement received for two of two residents (R1, R2) with records reviewed. This had the potential to affect all 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 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). Findings include: R1 admitted to the facility on December 31, 2021. R1's diagnoses included schizophrenia, anxiety, short term memory impairment, depression, and	0 450		

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0 450	Continued From page 14 history of suicidal ideation. R1's service plan, dated December 31, 2021, indicated R1 received comprehensive assessments as scheduled and safety checks each shift. R1's record included an acknowledgement form that indicated R1 received the Bill of Rights upon admission. The copy of the Bill of Rights in R1's chart was not the current Bill of Rights. R2 admitted to the facility on April 9, 2020. R2's diagnoses included mood disorder, opiate dependence, and borderline personality disorder. R2's service plan, dated April 9, 2020, indicated R2 received comprehensive assessments as scheduled, personal care services, home management, and a daily safety check. R2's record included an acknowledgement form that indicated R2 received the Bill of Rights upon admission. The copy of the Bill of Rights in R2s chart was not the current Bill of Rights. On January 19, 2022, at approximately 11:15 a.m., human resources manager (HR)-B confirmed the Bill of Rights given to residents was the version used under the comprehensive license and the licensee had not updated it after the assisted living license went into effect on August 1, 2021. The licensee's undated policy, Assisted Living Bill of Rights, indicated each resident would receive a written notice of the Assisted Living Bill of Rights and that it would be redistributed to residents following any revisions or modifications.	0 450		

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0 450	Continued From page 15 No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 450		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (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	0 480		

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0 480	Continued From page 16 or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated January 19, 2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 485 SS=F	144G.41 Subd 1. (13) (i) (A) and (C) Minimum Requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (A) menus must be prepared at least one week in advance, and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; (C) the facility cannot require a resident to include and pay for meals in their contract;	0 485		

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0 485	Continued From page 17 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure to offer at least three nutritious meals daily, according to the recommended dietary allowances in the United Stated Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables, with records reviewed. The licensee also failed to post a menu a week in advance that was made available to all residents. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On January 18, 2022, at approximately 1:00 p.m., the surveyor requested a copy of the week's menu. Unlicensed personnel (ULP)-C stated the facility does not utilize a weekly menu since the residents cook and prepare their own meals. On January 18, 2022, at approximately 2:40 p.m., R2 stated that while the facility does take them to grocery shop, she would rather not have to cook herself. R2 stated she wished the licensee prepared meals since it bogged her down and takes a lot of time as doing the cooking and clean up takes a lot of work. R2 stated she had brought her concerns up to management a few times and was told the licensee was looking at maybe hiring someone to cook but they had not made any	0 485		

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0 485	Continued From page 18 changes and she hadn't heard anything else. On January 18, 2022, at approximately 3:00 p.m., registered nurse (RN)-A stated the facility did not have a set menu and since the residents are independent, they prepare their own meals. RN-A stated the staff will help with meal preparation if requested. RN-A stated she was not sure if the residents would prefer to have the facility prepare meals for them. On January 19, 2022, at approximately 11:30 a.m., human resources manager (HR)-B stated the licensee felt they did provide three meals and two snacks per day since they brought residents to the store to buy groceries and since the residents were independent with preparation. HR-B stated she was not sure if the meal choices prepared by the residents would meet USDA guidelines. HR-B was aware the residents had made previous requests for the facility to prepare the meals for them. A policy on menu planning and meal service was requested, but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 485		
0 490 SS=F	144G.41 Subd 1 (13) (ii)-(vii) Minimum requirements (ii) weekly housekeeping; (iii) weekly laundry service; (iv) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services	0 490		

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0 490	Continued From page 19 appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance; (v) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance; (vi) provide culturally sensitive programs; and (vii) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to have a daily program of social and recreational activities based on individual and group interests, physical, mental, and psychosocial needs. This had the potential to affect all residents residing at 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) 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:	0 490		

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0 490	Continued From page 20 On January 18, 2022, at approximately 1:00 p.m., the surveyor requested a copy of the activities schedule. Unlicensed personnel (ULP)-C stated they do not utilize an activities schedule as the residents are independent and prefer to do their own things. On January 18, 2022 at approximately 3:00 p.m., registered nurse (RN)-A stated they do not have an activities calendar since residents are more independent and have their own activities they like to do on their own. A policy regarding the development and implementation of a daily activity program was requested, but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 490		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision.	0 510		

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0 510	Continued From page 21 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to establish and maintain an effective infection control program that complied with accepted health care, medical and nursing standards for infection control related to COVID-19, when they did not comply with MDH guidance for COVID-19 related to wearing appropriate PPE (personal protective equipment) and having a testing plan. This had the potential to affect all current residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: PPE USE On January 18, 2022, at approximately 1:00 p.m., the surveyor observed unlicensed personnel (ULP)-C wearing a surgical mask and no eye protection. On January 18, 2022, at approximately 3:00 p.m., the surveyor observed registered nurse (RN)-A wearing a surgical mask and no eye protection. On January 19, 2022, at approximately 9:30 a.m., the surveyor observed ULP-C wearing a surgical mask and no eye protection. On January 18, 2022, at approximately 3:10 p.m.,	0 510		

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0 510	Continued From page 22 RN-A stated she was not familiar with the updated PPE grid and that staff should be wearing surgical masks and eye protection. On January 29, 2022, at approximately 11:00 a.m., the surveyor observed human resources manager (HR)-B wearing a cloth mask and no eye protection. HR-B stated she was not familiar with the updated PPE grid or what staff should be wearing for PPE. The Minnesota Department of Health (MDH) guidance titled, "COVID-19 Personal Protective Equipment (PPE) and Source Control Grid," dated December 7, 2021, indicated on page 1 of 4, that health care workers (HCW) with face-to-face contact with COVID-19 negative clients in an area with high to substantial community transmission are to wear a medical-grade well-fitting facemask and eye protection. The CDC COVID Data Tracker showed the community transmission rate in Hennepin County was at a high level for January 19, 2022. TESTING PLAN A progress note in R2's chart indicated on January 1, 2022, R2 complained of not feeling well. A progress note on January 3, 2022, indicated R2 had body aches and fatigue and continued to not feel well. On January 19, 2022, at approximately 11:35 a.m., RN-A stated staff did not update her about R2 not feeling well and she was not aware R2 had COVID-like symptoms. RN-A stated she would have expected staff to check symptoms and possibly make an appointment for R2 to see the doctor. RN-A confirmed the licensee did not	0 510		

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0 510	Continued From page 23 have a testing plan for COVID and did not have a process in place of what to do if a resident displayed COVID-like symptoms. The MDH document titled, "Covid-19 Toolkit, Information for Long Term Care Facilities" last updated March 8, 2021, indicated on page 14, facilities should make a plan for testing with local health care organizations or MDH, maintain a very low threshold for testing of ill residents and staff, and facilitate specimen collection and testing as soon as possible. The licensee's policy, Covid-19 Infection Control Policies and Procedures indicated if a resident was exhibiting symptoms of Covid-19 including cough, fever, and shortness of breath, staff should contact the RN and also contact the administrator. Staff were directed to have the resident self-isolate in their room for 14 days from the day symptoms of Covid-19 began. The licensee's policy directed that staff would only wear eye protection when entering the room of a resident diagnosed with Covid-19. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 510		
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 e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact	0 550		

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0 550	Continued From page 24 information for the state and applicable regional 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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post the required information related to the grievance procedure and contact information for the Office of Ombudsman for Long-Term Care and Mental Health and Developmental Disabilities, as well as information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC). 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 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: The licensee lacked a posting to include all the required content about the facility's grievance procedure to include the name, telephone number and email contact information for the individuals who are responsible for handling grievances; the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities;	0 550		

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0 550	Continued From page 25 and the information for reporting suspected maltreatment to MAARC. During a facility tour on January 18, 2022, at approximately 1:15 p.m., the surveyor observed the main entrance and/or common areas lacked a posting of the grievance procedure; contact information for the Ombudsman offices; and information related to reporting suspected maltreatment to MAARC. On January 19, 2022, at approximately 10:45 a.m., human resources manager (HR)-B confirmed the required content noted above was not posted. The licensee lacked a policy related to posting of the adult abuse reporting and emergency numbers. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 550		
0 570 SS=C	144G.42 Subdivision 1 Display of license The original current license must be displayed at the main entrance of each assisted living facility. The facility must provide a copy of the license to any person who requests it. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to display the original current license at the main entrance of the assisted living facility as required. This had the potential to affect all of the licensee's current	0 570		

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0 570	Continued From page 26 residents, staff and visitors. 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 January 18, 2022, at approximately 12:35 p.m., upon entering the facility, the surveyor did not observe the original license to be posted. The licensee had a photocopy of the Assisted Living license and a copy of an expired Housing with Services license and Comprehensive services license posted. On January 18, 2022, at approximately 1:05 p.m., registered nurse (RN)-A confirmed the original Assisted Living license was not posted and confirmed the licensee no longer utilized the Comprehensive license. A policy on the display of the current license was requested, but not provided. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 570		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant	0 580		

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0 580	Continued From page 27 to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to implement and maintain a quality management program (QMP) appropriate to the size of the facility and relevant to the type of services provided. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 included: On January 18, 2022, at approximately 3:15 p.m., registered nurse/clinical nurse supervisor (RN)-A stated she wasn't sure if the licensee had a formal quality management program. RN-A stated they'd meet with licensed assisted living director (LALD)-D about once a month and talk about issues or things to work on, but she was not	0 580		

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0 580	Continued From page 28 aware of any documented minutes for those meetings. On January 19, 2022, at approximately 11:10 a.m., human resources manager (HR)-B stated she and LALD-D would meet a few times a week to talk about things to improve on, but they had not identified a specific project or item to work on. HR-B confirmed no minutes or documentation of the meetings were maintained. The licensee's policy, Quality Management Program, stated the facility would develop a continuous quality management program to identify, support, and maintain the facility's quality improvement efforts and provide quality services to its residents. The policy indicated outcome measurements from quality management activities would be monitored on a continuous basis and all results would be reported, at least annually, to the management team. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 580		
0 620 SS=E	144G.42 Subd. 6 Compliance with requirements for reporting ma 144G.42 Subd. 6. Compliance with requirements for reporting maltreatment of vulnerable adults; abuse prevention plan. (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported.	0 620		

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0 620	Continued From page 29 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) suspected maltreatment/self-neglect or complete a thorough investigation for two of two residents (R1, R2) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 R1 admitted to the facility on December 31, 2021. R1's diagnoses included schizophrenia, anxiety, short term memory impairment, depression, and history of suicidal ideation. R1's service plan, dated December 31, 2021, indicated R1 received comprehensive assessments as scheduled and safety checks each shift. R1's treatment record included the following daily checks: -suicide check once per shift; -manage depression, anxiety, and agitation once per shift;	0 620		

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0 620	Continued From page 30 -monitor for self-harm behavior once per shift; and -monitor for verbal and physical aggression once per shift. R1's mental health care plan, dated December 31, 2021, indicated R1 had a history of thinking/talking about hurting himself or others, reported feeling helpless, worthless or hopeless, and had extreme worry/agitation. Staff were directed to call 911 if a mental health emergency arose. On January 18, 2022, at approximately 12:45 p.m., unlicensed personnel (ULP)-C stated R1 left on Sunday (January 16, 2022), and ULP-C stated she was not sure where R1 was, and she had, "never seen him do this before." ULP-C stated R1 took all his belongings with him and had not been back to the facility since. On January 18, 2022, at approximately 3:00 p.m., human resources manager (HR)-B stated R1 moved out, but the licensee had not confirmed yet if R1 was discharging or not. HR-B stated R1 had extreme paranoia and had a disagreement with another resident at the facility before leaving with all his belongings. HR-B stated they had left a voicemail with R1's case manager but, because Monday (January 17, 2022) was a holiday, they were still waiting to hear back from the case manager before they decided to report R1's disappearance through MAARC or to call 911. HR-B stated the licensed assisted living director attempted to call R1 and left a voicemail after he did not return. HR-B confirmed staff did not know where R1 was and did not know if he was safe. On January 18, 2022, at approximately 3:30 p.m., registered nurse (RN)-A stated she was not	0 620		

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aware R1 had been missing until today (January 18, 2022). RN-A stated she would have expected staff to immediately notify her that R1 had packed up his belongings and left and confirmed the licensee should have filed a MAARC report. RN-A confirmed staff did not know R1's whereabouts and could not confirm if he was safe. RN-A later stated the licensee found out today (January 18, 2022) that R1 went to another group home and they're still not sure if he was discharging from their facility.

The licensee's undated Missing Client (resident) policy indicated if the client's (resident's) absence was not a planned absence and the absence could not be explained, the RN would call the Common Entry Point immediately, within 24 hours. The policy indicated if the client(resident) could not be located, the RN was to be notified and police were to be notified.

R2
R2 admitted to the facility on April 9, 2020.

R2's diagnoses included mood disorder, opiate dependence, and borderline personality disorder.

R2's service plan, dated April 9, 2020, indicated R2 received comprehensive assessments as scheduled, personal care services, home management, and a daily safety check.

R2's mental health care plan, dated October 21, 2021, indicated R2 sometimes felt helpless, worthless, or hopeless and could have extreme worry or agitation, and sometimes experienced extreme mood changes. Staff were directed to call 911 if a mental health emergency arose.

On January 11, 2022, a progress note indicated

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0 620	Continued From page 32 R2 "was feeling emotional today and complained about the guy she is seeing. She said that being with him makes her feel suicidal and that she hasn't felt that way in a long time." On January 12, 2022, a progress note indicated R2 "was feeling distraught today due to the guy she was seeing. She feels afraid and thinks he's going to kill her. [R2] said that she threatened the guy she was seeing with suicide. She told him she would take a bunch of sleeping pills and that he did not care." On January 19, 2022, at approximately 11:40 a.m., RN-A stated the licensee did not report anything to MAARC as they wanted to hear what R2's county case manager thought about the situation. RN-A confirmed R2's health care provider was not updated with the new suicidal ideation and that the only intervention the licensee put in to place was every two-hour safety checks. RN-A stated the licensee had considered a no trespass order if R2's boyfriend showed up to the home. RN-A confirmed that no interventions to protect R2 from threats made by the boyfriend were implemented and they had not completed any assessments to see if R2 was being abused by the boyfriend. On January 19, 2022, at approximately 11:50 a.m., ULP-C stated R2 had been having a lot of trouble with a guy was emotionally distressed and expressed a plan to kill herself by taking a bunch of pills. ULP-C stated R2's boyfriend knew where she lived, and he said he might come by and destroy the property. ULP-C stated she had notified the nurse and was told she should increase the frequency of safety checks on R2 to every two hours. ULP-C stated the nurse did not implement any other interventions to protect R2	0 620		

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	34760	A. BUILDING: _____ B. WING _____	01/19/2022

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0 620	Continued From page 33 from self-harm or from abuse by R2's boyfriend. ULP-C stated she did not know how to complete a MAARC report and did not think to file one in either situation. The licensee's undated Reporting Maltreatment of Vulnerable Adult policy indicated all facility personnel rendering service to a resident are mandated to report maltreatment or injuries to their supervisor or to MAARC. The policy indicated the facility would conduct an internal investigation for all reportable events. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 620		
0 630 SS=E	144G.42 Subd. 6 Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan was developed to include the	0 630		

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0 630	Continued From page 34 required content for two of two residents (R1, R2) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 R1 admitted to the facility on December 31, 2021. R1's diagnoses included schizophrenia, anxiety, short term memory impairment, depression, and history of suicidal ideation. R1's service plan, dated December 31, 2021, indicated R1 received comprehensive assessments as scheduled and safety checks each shift. R1's Individual Abuse Prevention Plan (IAPP), dated December 31, 2021, indicated R1 did not have any signs of abuse or neglect. The IAPP indicated R1 did not misuse or abuse substances, did not have any sensory deficits that affects safety, did not have self-abusive behavior, did not have difficulty making decisions, was willing to follow the plan of care, and was not at risk of abuse from others or at risk of abusing others. R1's treatment record for January 2022, included	0 630		

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0 630	Continued From page 35 the following daily checks: -suicide check once per shift; -manage depression, anxiety, and agitation once per shift; -monitor for self-harm behavior once per shift; and -monitor for verbal and physical aggression once per shift. R1's mental health care plan, dated December 31, 2021, indicated R1 had a history of thinking/talking about hurting himself or others, reported feeling helpless, worthless or hopeless, and had extreme worry/agitation. Staff were directed to call 911 if a mental health emergency arose. On January 19, 2022, at approximately 12:00 p.m., registered nurse (RN)-A confirmed R1's IAPP did not line up with R1's mental health care plan or R1's diagnoses. RN-A stated the IAPP was "not an assessment but an objective assessment" as she had interviewed R1 and the information reflected R1's responses. RN-A stated R1 did not feel he had any vulnerability or safety issues, so the IAPP reflected R1's answers. RN-A confirmed the IAPP was not an accurate assessment or reflection of R1's current vulnerabilities. R2 R2 admitted to the facility on April 9, 2020. R2's diagnoses included mood disorder, opiate dependence, and borderline personality disorder. R2's service plan, dated April 9, 2020, indicated R2 received comprehensive assessments as scheduled, personal care services, home management, and a daily safety check.	0 630		

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0 630	Continued From page 36 R2's IAPP, last updated November 12, 2021, indicated the resident did not have any current or previous history or thoughts of harming self or ending their life, R2 did not have self-abusive behavior, was not at risk of abuse from others, and did not engage in self-injurious behaviors. The IAPP further indicated R2 was able to identify potentially dangerous situations, was unable to deal with verbally/physically aggressive persons and had a history of being a victim. R2's treatment record for January 2022 included the following daily checks: -manage agitation; -manage behaviors each shift including anxiety, agitation, mood swings; and -remind resident of appointments due to forgetfulness sometimes. R2's mental health care plan, dated October 21, 2021, indicated R2 sometimes felt helpless, worthless, or hopeless and could have extreme worry or agitation, and sometimes experienced extreme mood changes. Staff were directed to call 911 if a mental health emergency arose. On January 11, 2022, a progress note indicated R2 "was feeling emotional today and complained about the guy she is seeing. She said that being with him makes her feel suicidal and that she hasn't felt that way in a long time." On January 12, 2022, a progress note indicated R2 "was feeling distraught today due to the guy she was seeing. She feels afraid and thinks he's going to kill her. [R2] said that she threatened the guy she was seeing with suicide. She told him she would take a bunch of sleeping pills and that he did not care."	0 630		

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0 630	Continued From page 37 On January 19, 2022, at approximately 12:00 p.m., RN-A confirmed R2's IAPP had not been updated to reflect R2's suicidal comments and risk for being abused by the boyfriend. RN-A confirmed the IAPP and mental health care plan included conflicting statements of R2's vulnerabilities. The licensee's undated Abuse Prevention Plan policy indicated all residents admitted to the facility would be assessed for their susceptibility to abuse by other individuals, including other vulnerable adults and their risk of abusing other vulnerable adults. The policy indicated a statement of the specific measures that will be taken to minimize the risk of abuse would be developed. The policy indicated the plan would be reviewed as necessary and adjusted to respond to the resident's needs. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 630		
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	0 640		

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0 640	Continued From page 38 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 and interview, the licensee failed to support protection and safety by not posting information and phone numbers for reporting to the Minnesota Adult Abuse Reporting Center (MAARC) and 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: The licensee lacked the following: - posting of 911emergency number in common areas and near telephones provided by the Assisted Living facility; and - posting of information and the reporting number for the MAARC to report suspected maltreatment of a vulnerable adult under section 626.557. During a facility tour on January 18, 2022, at approximately 12:45 p.m., the surveyor observed the facility's main entry area and common areas lacked the required posted information.	0 640		

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0 640	Continued From page 39 On January 19, 2022, at approximately 10:45 a.m., human resources manager (HR)-B confirmed the required content noted above was not posted. The licensee lacked a policy related to posting of the adult abuse reporting and emergency numbers. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 640		
0 650 SS=E	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and	0 650		

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0 650	Continued From page 40 (6) documentation of the background study as required under section 144.057. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure current employee records were maintained to include all required content for two of two employees (registered nurse (RN)-A and unlicensed personnel (ULP)-C) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: RN-A RN-A was hired March 17, 2020, to provide direct care and services to the licensee's residents and to provide oversight and supervision to the licensee's unlicensed personnel. RN-A's employee file lacked the following required content:	0 650		

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0 650	Continued From page 41 -records of orientation, required annual training and infection control training, and competency evaluations; -documentation of annual performance reviews that identify areas of improvement needed and training needs; ULP-C ULP-C was hired September 14, 2020, to provide direct care and services to the licensee's residents. ULP-C's employee file lacked the following required content: -records of orientation, required annual training and infection control training, and competency evaluations; -current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; -documentation of annual performance reviews that identify areas of improvement needed and training needs; On January 19, 2022, at approximately 11:00 a.m., human resources manager (HR)-B confirmed RN-A and ULP-C's records were missing the above-mentioned required content. The licensee's undated Performance Evaluations policy indicated a competency-based evaluation would be conducted for all employees after one year of employment and at least annually thereafter. The licensee's undated Personnel Records policy indicated personnel files would contain the following required content: -evidence of current professional licensure, registration, or certification if licensure,	0 650		

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0 650	Continued From page 42 registration, or certification is required by this chapter or rules; -records of orientation, required annual training and infection control training, and competency evaluations; -current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; -documentation of annual performance reviews that identify areas of improvement needed and training needs; - for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and -documentation of the background study as required under section 144.057. No additional information was provided. TIME PERIOD FOR CORRECTION: Seven (7) 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	0 660		

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0 660	Continued From page 43 the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the provider established and maintained a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) current screening for active or latent TB for one of two employees (registered nurse (RN)-A). In addition, the licensee failed to ensure TB training was completed for one of two employees (unlicensed personnel (ULP)-C) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The facility's TB risk assessment was completed April 26, 2021, and was determined to be a low risk level. SCREEN FOR ACTIVE/LATENT TB RN-A's employee record lacked documentation of a two-step screening for active/latent TB. RN-A's record included documentation of a negative Tuberculin skin test (TST) completed on November 13, 2019; however, RN-A was hired on	0 660		

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0 660	Continued From page 44 March 17, 2020, to provide direct care to residents and oversee licensed and unlicensed personnel at the facility. On January 19, 2022, at approximately 10:40 a.m., human resources manager (HR)-B confirmed RN-A had not completed screening for active/latent TB within 90 days of hire. TB TRAINING ULP-C was hired September 14, 2020 to provide direct care and services to the licensee's residents. ULP-C's employee record lacked documentation of completion of training related to TB. On January 19, 2022, at approximately 10:40 a.m., HR-B confirmed ULP-C had not completed TB training. The licensee's undated Tuberculosis Screening policy indicated each employee having direct contact with residents would have documentation of baseline health symptom screening prior to providing care to residents, including TB skin testing via the Mantoux method. The licensee's undated Tuberculosis Prevention and Control policy indicated training and information would be provided to all employees at the time of hire and annually. The policy indicated the training would include information on signs and symptoms of TB, health screening and therapy, facility specific protocols, and use of respiratory protection equipment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		

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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 tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview and record review the licensee failed to have a written emergency preparedness plan with all the required content as defined in Appendix Z, with record review. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 680		

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0 680	Continued From page 46 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 January 18, 2022, at approximately 12:45 p.m.., the surveyor requested to view the licensee's emergency preparedness plan (EPP). The plan contained a binder of various emergency situations, including how staff should respond. The licensee's policies contained direction on making an emergency plan, and the policies listed various emergency situations (such as heat, several weather emergencies, emergency evacuations, plan activations); however, the procedures spelled out in the plan were generic, lacking specificity to the licensee. The licensee's plan lacked the following required content: -all hazards-based emergency preparedness program with a risk assessment considering all hazards that may impact all or a portion of the facility; -an assessment of the at-risk population's needs; -a process for emergency preparedness (EPS) cooperation with state and local EP officials/organizations; -policies and procedures that are stored in a central place; -subsistence needs for staff and residents during emergency situation; -procedure for tracking staff and residents; -development of all policies and procedures,	0 680		

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	34760	A. BUILDING: _____ B. WING _____	01/19/2022

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0 680	Continued From page 47 based on risk assessment, and additional policies individualized to the facility for: potential evacuation, sheltering in place, handling medical documents and how the facility will provide care under an 1135 waiver declared by the Secretary; -a plan for sheltering in place when not able to evacuate; -transfer agreements and/or contracts with other facilities/providers to receive residents in the event of evacuation or other limitations that would impact the continuity of services; and -a communication plan with the following required content: names and contact information for staff/entities providing services under an agreement, residents' physicians, other facilities, volunteers, federal, state, tribal, regional, and local emergency preparedness staff, state licensing and certification agency, Office of the State Long Term Care Ombudsman, other sources of assistance, a plan for communicating during an emergency, including primary and alternative means for communication, procedures for sharing medical information to maintain continuity of care; and procedures for sharing the emergency plan with family members and residents. On January 18, 2022, at approximately 3:00 p.m., human resources manager (HR)-B stated she was not familiar with Appendix Z and was not aware of the required content for the emergency preparedness plan. HR-B confirmed the licensee's emergency preparedness plan did not contain all the required content. The licensee's undated Emergency Management Policy indicated the licensee would have a plan in place to ensure the safety and well-being of residents and employees during period of an emergency or a disaster that disrupts facility	0 680		

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0 680	Continued From page 48 services. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide interconnection of smoke alarms	0 780		

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0 780	Continued From page 49 for resident bedrooms #1 and #2 as required by Minnesota Statutes, 144G.45, Subd. 2. This has the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On January 20, 2022, between 3:00 p.m. and 4:15 p.m., survey staff toured the home about required smoke alarms with the unlicensed personnel (ULP)-E. At approximately 3:30 p.m., it was observed that resident bedrooms #1 and #2 only sounded local and were not interconnected with the building alarm system such tha all other smoke alarms in the home to sound throughout for notification as required. This finding was evident when all other smoke alarms in the home (living room, the lower level bedrooms, and the basement common area) were tested and the interconnection of those smoke alarms functioned properly. The ULP-E verified this finding as she received a phone call at approximately 3:45 p.m. to explain to her that all smoke alarms except for bedroom #1 and #2 were recently replaced. On January 20, 2022. at approximately 4:30 p.m., the human resources manager (HR)-B joined the interview by phone. The findings were acknowledged by the ULP-E and and the HR-B.	0 780		

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0 780	Continued From page 50 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 780		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain portable fire extinguishers in accordance with the State Fire Code as required by MN Statute 144G.45 Subd(a)(2). This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	0 790		

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0 790	Continued From page 51 On January 20, 2022, at approximately 4:10 p.m., during the tour of the home with the unlicensed personnel (ULP)-E, survey staff observed that the portable fire extinguisher was improperly located for ready access. The extinguisher was sitting on top of a filing cabinet tucked in a corner behind the dining table and kitchen counter. In addition, the extinguisher was also observed with no tags attached or records to show the required annual service or monthly visual inspections from this year, or any previous years. On January 20, 2022. at approximately 4:30 p.m., the human resources manager (HR)-B joined the interview by phone. The finding was acknowledged by the ULP-E and and the HR-B. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
0 800 SS=E	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment of the facility in a continuous state of good repair and operation. This has the potential to directly affect	0 800		

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0 800	Continued From page 52 the health, safety, and well-being of all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). On January 20, 2022, between 3:00 p.m. and 4:15 p.m., survey staff toured the home with the unlicensed personnel (ULP)-E and the following findings were observed. -The fan in the upper bathroom was dismantled and needed to be repaired. -The cover on the exhaust fan in the lower bathroom was heavily layered with dust. On January 20, 2022. at approximately 4:30 p.m., the human resources manager (HR)-B joined the interview by phone and the findings were acknowledged by the HR-B and the ULP-E. No further information was provided. 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	0 810		

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0 810	Continued From page 53 maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to provide the required documentation on fire safety and evacuation plans, training, and evacuation drills. This has the potential to directly affect the safety of all residents receiving assisted living care,	0 810		

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0 810	Continued From page 54 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). On January 20, 2022, at approximately 4:15 p.m, survey staff requested the fire safety and evacuation plan, drills, and training documentation from the unlicensed personnel (ULP)-E for review. The findings include: 1. The fire safety and evacuation plan was not complete in content and not readily available. 2. The fire safety and evacuation plan lacked a layout plan of the home to show the location of rooms, numbers of sleeping rooms, and exits. 3. The fire safety and evacuation plan documentation lacked the specific procedures for employee actions to be taken in the event of a fire and fire protection procedures necessary for addressing all residents including any unique resident-specific situations during an evacuation such as residents who were wheelchair-bound, on walkers, and needing assistance during an evacuation. . 4. No fire protection procedures for residents. 5. No evidence of employee evacuation drills that have been performed as required. 6. No policy or records of employee training on fire safety and evacuation to meet the minimum required training upon hire and twice a year. 7. No policy or records provided to show training	0 810		

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0 810	Continued From page 55 of residents that can self assist in their evacuation during the proper actions to be taken in the event of a fire including movement, evacuation, or relocation. On January 20, 2022. at approximately 4:30 p.m., the human resources manager (HR)-B joined the interview by phone. The findings were acknowledged by the ULP-E and and the HR-B. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	0 810		
0 900 SS=F	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed.	0 900		

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0 900	Continued From page 56 (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop and execute a written contract with the required content to provided assisted living services for two of two residents (R1, R2) with records reviewed. The licensee also failed to provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract. This has the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 and R2's records lacked a written contract	0 900		

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0 900	Continued From page 57 which included all of the terms concerning the provisions of the following as required: - housing; - assisted living services, whether provided directly by the facility or by management agreement or other agreement; and - the resident's service plan, if applicable. In addition, the resident records lacked evidence the contract had been fully executed as the facility must: - offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; - give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed; and - the facility must offer the resident the opportunity to identify a designated representative. On January 19, 2022, at approximately 11:20 a.m., human resources manager/HR-B stated they thought the contract they were utilizing was correct and did not realize there were changes made with the assisted living licensure. The licensee's undated policy, Assisted Living Contracts, indicated the facility would establish a contract with each client at the time of admission to the program and the contract would include the required contract elements for compliance with the statute. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 900		

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0 950 SS=F	144.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to offer two of two residents (R1, R2) the opportunity to identify a designated representative with records reviewed.	0 950		

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0 950	Continued From page 59 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On January 19, 2022, at approximately 11:20 a.m., human resources manager/HR-B stated they thought the contract they were utilizing was correct and did not realize there were changes made with the assisted living licensure. HR-B confirmed their contracts did not offer residents the opportunity to designate a representative and the same contract was being used with all residents. The licensee's undated policy, Assisted Living Contracts, indicated the facility would establish a contract with each client (resident) at the time of admission to the program and the contract would include the required contract elements for compliance with the statute. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950		
01290 SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section	01290		

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01290	Continued From page 60 144.057 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: Based on interview and record review, the licensee failed to ensure a background study was completed as required for one of two employees (registered nurse (RN)-A) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: RN-A was hired on March 17, 2020, under the comprehensive home care license and began providing assisted living services on August 1, 2021. RN-A's employee file lacked documentation of a current background study. RN-A's file contained a background study dated April 4, 2019, and	01290		

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	34760	A. BUILDING: _____ B. WING _____	01/19/2022

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01290	Continued From page 61 indicated RN-A's background study had cleared. The background study was completed under the licensee's comprehensive license and was not affiliated to the assisted living license when the licensee converted to assisted living licensure on August 1, 2021. On January 19, 2022, at approximately 10:40 a.m., human resources manager (HR)-B stated RN-A's background check was initially submitted when the licensee was applying for a comprehensive license. HR-B stated her hire date was not until almost a year later since the licensee did not take on any clients until March 2020. HR-B confirmed a new background study was not completed when RN-A began working for the licensee under the assisted living license. The licensee's undated Background Studies policy indicated a background study would be completed at the time of hire. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days.	01290		
01370 SS=D	144G.61 Subd. 2 Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (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;	01370		

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01370	Continued From page 62 (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 observation, interview and record review, the licensee failed to ensure training and competency was completed for one of one employee, unlicensed personnel ((ULP)-C) to include all required content with records reviewed.	01370		

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01370	Continued From page 63 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-C was hired September 14, 2020, to provide direct care and services to the licensee's residents. ULP-C's employee file contained a partially completed home health aide skills checklist self-appraisal of learning needs form and a blank unlicensed personnel competency evaluation form. ULP-C's employee file lacked documentation of training and competency evaluations for the following topics: -documentation requirements for all services provided; -reports of changes in the resident's condition to the supervisor designated by the facility; -basic infection control, including blood-borne pathogens; -maintenance of a clean and safe environment; -appropriate and safe techniques in personal hygiene and grooming, including: -hair care and bathing; -care of teeth, gums, and oral prosthetic devices; -care and use of hearing aids; and -dressing and assisting with toileting; -training on the prevention of falls;	01370		

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01370	Continued From page 64 -standby assistance techniques and how to perform them; -medication, exercise, and treatment reminders; -basic nutrition, meal preparation, food safety, and assistance with eating; -preparation of modified diets as ordered by a licensed health professional; -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; -awareness of confidentiality and privacy; -understanding appropriate boundaries between staff and residents and the resident's family; -procedures to use in handling various emergency situations; and -awareness of commonly used health technology equipment and assistive devices. On January 19, 2022, at approximately 10:30 a.m., human resources manager (HR)-B confirmed ULP-C did not have documentation the above-mentioned training had been completed. The licensee's undated Qualifications, Training, and Competency policy indicated each personnel record would include record of all required training for unlicensed personnel and competency determinations. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01380 SS=D	144G.61 Subd. 2 Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and	01380		

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01380	Continued From page 65 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 observation, interview and record review, the licensee failed to ensure training and competency was completed for one of one employee, unlicensed personnel ((ULP)-C) to include all required content with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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-C was hired September 14, 2020, to provide direct care and services to the licensee's	01380		

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01380	Continued From page 66 residents. ULP-C's employee file contained a partially completed home health aide skills checklist self-appraisal of learning needs form and a blank unlicensed personnel competency evaluation form. ULP-C's employee file lacked documentation of training and competency evaluations for the following topics: -observing, reporting, and documenting resident status; -basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; -reading and recording temperature, pulse, and respirations of the resident; -recognizing physical, emotional, cognitive, and developmental needs of the resident; -safe transfer techniques and ambulation; -range of motioning and positioning; and -administering medications or treatments as required. On January 19, 2022, at approximately 10:30 a.m., human resources manager (HR)-B confirmed ULP-C did not have documentation the above-mentioned training had been completed. The licensee's undated Qualifications, Training, and Competency policy indicated each personnel record would include record of all required training for unlicensed personnel and competency determinations. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one	01380		

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01380	Continued From page 67 (21) days	01380		
01440 SS=D	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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure direct supervision of staff performing delegated tasks was provided within 30 calendar days after the date on which the individual began working for the licensee for one of one unlicensed personnel ((ULP)-C) with records reviewed.	01440		

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01440	Continued From page 68 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-C was hired September 14, 2020, to provide direct care and services to the licensee's residents. ULP-C's employee record lacked documentation of a registered nurse (RN) supervising ULP-C performing delegated tasks within 30 days of beginning work with the licensee. On January 19, 2022, at approximately 10:30 a.m., human resources manager (HR)-B confirmed ULP-C did not have a 30-day supervision completed. HR-B thought that was part of their process and the nurse would normally do a 30-day supervision of the unlicensed staff. A policy on the RN completing a 30-day supervision was requested, but not provided. 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 69 (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 70 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 all required content of orientation was provided to two of two employees (registered nurse (RN)-A and unlicensed personnel (ULP)-C). 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: RN-A RN-A was hired March 17, 2020, to provide direct care and services to the licensee's residents and to provide oversight and supervision to the licensee's unlicensed personnel.	01470		

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01470	Continued From page 71 RN-A's employee file lacked evidence the employee received orientation on the following topics: an overview the assisted living statutes; -an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; -handling of emergencies and use of emergency services; -compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); -the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; -handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; -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 -a review of the types of assisted living services the employee will be providing and the facility's category of licensure. RN-A's employee file contained an EduCare assisted living and home care nurse orientation checklist. The completion date of the classes was left blank, but the bottom of the sheet was signed	01470		

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01470	Continued From page 72	01470		

June 11, 2020. The orientation checklist contained approximately 16 hours of training courses that could be completed via the online training module.

On January 19, 2022, at approximately 11:00 a.m., human resources manager (HR)-B stated she thought the date on the bottom indicated the classes were assigned but HR-B was not sure if the education had actually been completed. A copy of RN-A's EduCare transcript was requested, but not provided.

ULP-C
ULP-C was hired September 14, 2020, to provide direct care and services to the licensee's residents.

ULP-C's employee file lacked evidence the employee received orientation on the following topics:
an overview the assisted living statutes;
-an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person;
-handling of emergencies and use of emergency services;
-compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC);
-the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;
-the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person;
-handling of residents' complaints, reporting of complaints, and where to report complaints,

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01470	Continued From page 73 including information on the Office of Health Facility Complaints; -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 -a review of the types of assisted living services the employee will be providing and the facility's category of licensure. ULP-C's employee file contained a partially filled out new hire personnel file checklist. The section for orientation paperwork and required training was not filled out. On January 19, 2022, at approximately 11:00 a.m., HR-B confirmed ULP-C did not have evidence of required orientation in her personnel file. HR-B thought ULP-C had received orientation but was not able to provide any documentation. The licensee's undated Facility Employee Orientation policy indicated employees would complete an orientation on topics required by Minnesota statutes and rules for assisted living. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01490 SS=F	144G.63 Subd. 4 Training required relating to dementia All direct care staff and supervisors providing	01490		

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01490	Continued From page 74	01490		

direct services must demonstrate an understanding of the training specified in section 144G.64.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to ensure all staff received dementia care as required for two of two employees (registered nurse (RN)-A and unlicensed personnel (ULP)-C).

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:

RN-A
RN-A was hired March 17, 2020, to provide direct care and services to the licensee's residents and provide oversight and supervision to the licensee's unlicensed personnel.

RN-A's employee record lacked documentation of completion of eight hours of initial training within 120 working hours of first day of employment that included:
-an explanation of Alzheimer's disease and other dementias;
-assistance with activities of daily living;
-problem solving with challenging behaviors;
-communication skills; and
-person-centered planning and service delivery.

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PARADISE ASSISTED LIVING INC	10829 VINCENT AVENUE SOUTH BLOOMINGTON, MN 55431

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01490	Continued From page 75 RN-A's employee file contained an EduCare assisted living and home care nurse orientation checklist. The completion date of the classes was left blank, but the bottom of the sheet was signed June 11, 2020. The orientation checklist contained approximately 12 hours of dementia training that could be completed via the online training module. On January 19, 2022, at approximately 11:00 a.m., human resources manager (HR)-B stated she thought the date on the bottom indicated the classes were assigned but HR-B was not sure if the education had actually been completed. A copy of RN-A's EduCare transcript was requested, but not provided. ULP-C ULP-C was hired September 14, 2020, to provide direct care and services to the licensee's residents. ULP-C's record lacked documentation of completion of eight hours of initial training within 160 working hours of the first day of employment that included: -an explanation of Alzheimer's disease and other dementias; -assistance with activities of daily living; -problem solving with challenging behaviors; -communication skills; and -person-centered planning and service delivery. On January 19, 2022, at approximately 11:00 a.m., human resources manager (HR)-B confirmed RN-A and ULP-C were missing the required training. HR-B confirmed there was no process in place currently to ensure staff completed the required dementia training upon hire. The licensee's undated Dementia Care Training	01490		

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01490	Continued From page 76 policy indicated supervisors of direct care staff would have eight hours of initial training within 120 hours of first day of employment and direct care staff would have eight hours of initial training within 160 hours of first day of employment. The training topics were the same for both supervisors of direct care staff and direct care staff, and would include: -an explanation of Alzheimer's disease and other dementias; -assistance with activities of daily living; -problem solving with challenging behaviors; -communication skills; and -person-centered planning and service delivery. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	01490		
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective	01500		

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01500	Continued From page 77	01500		

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

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01500	Continued From page 78 This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to ensure all employees had at least eight hours of annual training for each 12 months of employment that included the required content for two of two employees (registered nurse (RN)-A, unlicensed personnel (ULP)-C) with employee records reviewed. This had the potential to affect all of the licensee's residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at 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: RN-A RN-A was hired March 17, 2020, to provide direct care and services to the licensee's residents and to provide oversight and supervision to the licensee's unlicensed personnel. RN-A's file lacked evidence RN-A completed annual training for 2021 to include the following content: -training on reporting of maltreatment of vulnerable adults under section 626.557; -review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; -review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal	01500		

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01500	Continued From page 79 of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; -effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; -review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. ULP-C ULP-C was hired September 14, 2020 to provide direct care and services to the licensee's residents. ULP-C's file lacked evidence annual training had been completed for 2021 to include the following content: -training on reporting of maltreatment of vulnerable adults under section 626.557; -review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; -review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; -effective approaches to use to problem solve	01500		

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01500	Continued From page 80 when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; -review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. On January 19, 2022, at approximately 10:50 a.m., human resources manager (HR)-B confirmed RN-A and ULP-C had not received any continuing education in the past 12 months and there was not a plan in place to ensure all employees completed required annual training. HR-B stated they would have meetings about some of the required topics but lacked documentation of the training. The licensee's undated Annual Training Requirements Policy indicated all staff providing direct care services would complete at least eight hours of annual training for each 12 months of employment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		
01620 SS=F	144G.70 Subd. 2 Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident	01620		

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01620	Continued From page 81 reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed a timely comprehensive reassessment using the uniform assessment tool for two of two residents (R1, R2) as required with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), 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).	01620		

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01620	Continued From page 82 The findings include: R1 R1 admitted to the facility on December 31, 2021. R1's diagnoses included schizophrenia, anxiety, short term memory impairment, depression, and history of suicidal ideation. R1's service plan, dated December 31, 2021, indicated R1 received comprehensive assessments as scheduled and safety checks each shift. R1's chart included a comprehensive admission assessment dated December 31, 2021. The assessment lacked the required content for the Uniform Assessment Tool. R1 was due to be reassessed on January 14, 2022, 14 days after admission. R1's chart lacked evidence a 14-day assessment was completed. R2 R2 admitted to the facility on April 9, 2020. R2's diagnoses included mood disorder, opiate dependence, and borderline personality disorder. R2's service plan, dated April 9, 2020, indicated R2 received comprehensive assessments as scheduled, personal care services, home management, and a daily safety check. R2's chart included 90-day assessments, dated August 19, 2021 and November 16, 2021. The assessments lacked the required content for the Uniform Assessment Tool.	01620		

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01620	Continued From page 83 On January 19, 2022, at approximately 11:10 a.m., RN-A confirmed the assessment tool used by the licensee for all resident assessments did not contain all of the required content. RN-A confirmed R1 did not have a 14-day assessment completed as RN-A was quarantining due to an exposure to Covid and was not able to come in and complete the assessment by the time it was due. The licensee's undated Nursing Assessment and Reassessment of Residents policy indicated resident reassessment and monitoring would be conducted no more than 14 calendar days after initiating services. The policy indicated the assessment would include the requirements outlined in the Minnesota Rules. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01620		
01650 SS=E	144G.70 Subd. 4 Service plan, implementation, and revisions t (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service	01650		

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01650	Continued From page 84 cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan included the required content for two of two residents (R1, R2) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 R1 admitted to the facility on December 31, 2021. R1's diagnoses included schizophrenia, anxiety,	01650		

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01650	Continued From page 85 short term memory impairment, depression, and history of suicidal ideation. R1's service plan, dated December 31, 2021, indicated R1 received comprehensive assessments as scheduled and safety checks each shift. R1's service plan lacked the following required content: - a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; -the identification of staff or categories of staff who will provide the services; R1's treatment record included the following daily checks: -suicide check once per shift; -manage depression, anxiety, and agitation once per shift; -monitor for self-harm behavior once per shift; and -monitor for verbal and physical aggression once per shift. R2 R2 admitted to the facility on April 9, 2020. R2's diagnoses included mood disorder, opiate dependence, and borderline personality disorder. R2's service plan, dated April 9, 2020, indicated R2 received comprehensive assessments as scheduled, personal care services, home management, and a daily safety check. R2's service plan lacked the following required content:	01650		

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01650	Continued From page 86 - a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; -the identification of staff or categories of staff who will provide the services; R2's treatment record for January 2022 included the following daily checks: -manage agitation; -manage behaviors each shift including anxiety, agitation, mood swings; and -remind resident of appointments due to forgetfulness sometimes. On January 19, 2022, at approximately 12:20 p.m., registered nurse (RN)-A confirmed the service plan did not list the tasks being performed for managing and monitoring R1 and R2's mental health needs. RN-A confirmed the service plan did not list the fees for services R1 and R2 received. A policy regarding the content of service plans was requested but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
03000 SS=E	626.557 Subd. 3 Timing of report (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the	03000		

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common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless:
(1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or
(2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4).
(b) A person not required to report under the provisions of this section may voluntarily report as described above.
(c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point.
(d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency.
(e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The

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lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c.

This MN Requirement is not met as evidenced by:
Based on observation, interview and record review, the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) suspected maltreatment/self-neglect or complete a thorough investigation for two of two residents (R1, R2) with records reviewed.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).

The findings include:

R1
R1 admitted to the facility on December 31, 2021.

R1's diagnoses included schizophrenia, anxiety, short term memory impairment, depression, and history of suicidal ideation.

R1's service plan, dated December 31, 2021, indicated R1 received comprehensive assessments as scheduled and safety checks each shift.

R1's treatment record included the following daily checks:

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PARADISE ASSISTED LIVING INC	10829 VINCENT AVENUE SOUTH BLOOMINGTON, MN 55431

(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
03000	Continued From page 89 -suicide check once per shift; -manage depression, anxiety, and agitation once per shift; -monitor for self-harm behavior once per shift; and --monitor for verbal and physical aggression once per shift. R1's mental health care plan, dated December 31, 2021, indicated R1 had a history of thinking/talking about hurting himself or others, reported feeling helpless, worthless or hopeless, and had extreme worry/agitation. Staff were directed to call 911 if a mental health emergency arose. On January 18, 2022, at approximately 12:45 p.m., unlicensed personnel (ULP)-C stated R1 left on Sunday (January 16, 2022), and ULP-C stated she was not sure where R1 was, and she had "never seen him do this before." ULP-C stated R1 took all his belongings with and had not been back to the facility since. On January 18, 2022, at approximately 3:00 p.m., human resources manager (HR)-B stated R1 moved out but the licensee had not confirmed yet if R1 was discharging or not. HR-B stated R1 had extreme paranoia and had a disagreement with another resident at the facility before leaving with all his belongings. HR-B stated they had left a voicemail with R1's case manager but because Monday (January 17, 2022) was a holiday, they were still waiting to hear back from the case manager before they decided if they were going to report R1's disappearance through MAARC or call 911. HR-B stated the licensed assisted living director attempted to call R1 and left a voicemail after he did not return. HR-B confirmed staff did not know where R1 was and did not know if he	03000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34760	A. BUILDING: _____ B. WING _____	01/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARADISE ASSISTED LIVING INC	10829 VINCENT AVENUE SOUTH BLOOMINGTON, MN 55431

(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
03000	Continued From page 90 was safe. On January 18, 2022, at approximately 3:30 p.m., registered nurse (RN)-A stated she was not aware R1 had been missing until today (January 18, 2022). RN-A stated she would have expected staff to immediately notify her that R1 had packed up his belongings and left and confirmed the licensee should have filed a MAARC report. RN-A confirmed staff did not know R1's whereabouts and could not confirm if he was safe. RN-A later stated they found out today (January 18, 2022) that R1 went to another group home and they're still not sure if he was discharging from their facility. The licensee's undated Missing Client (resident) policy indicated if the client's (resident's) absence was not a planned absence and the absence cannot be explained, the RN would call the Common Entry Point immediately, within 24 hours. The policy indicated if the client (resident) could not be located, the RN was to be notified and police were to be notified. R2 R2 admitted to the facility on April 9, 2020. R2's diagnoses included mood disorder, opiate dependence, and borderline personality disorder. R2's service plan, dated April 9, 2020, indicated R2 received comprehensive assessments as scheduled, personal care services, home management, and a daily safety check. R2's mental health care plan, dated October 21, 2021, indicated R2 sometimes felt helpless, worthless, or hopeless and could have extreme worry or agitation, and sometimes experienced	03000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34760	A. BUILDING: _____ B. WING _____	01/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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03000	Continued From page 91	03000		

extreme mood changes. Staff were directed to call 911 if a mental health emergency arose.

On January 11, 2022, a progress note indicated R2 "was feeling emotional today and complained about the guy she is seeing. She said that being with him makes her feel suicidal and that she hasn't felt that way in a long time."

On January 12, 2022, a progress note indicated R2 "was feeling distraught today due to the guy she was seeing. She feels afraid and thinks he's going to kill her. [R2] said that she threatened the guy she was seeing with suicide. She told him she would take a bunch of sleeping pills and that he did not care."

On January 19, 2022 at approximately 11:40 a.m., RN-A stated the licensee did not report anything to MAARC as they wanted to hear what R2's county case manager thought about the situation. RN-A confirmed R2's health care provider was not updated with the new suicidal ideation and that the only intervention the licensee put in to place was every two-hour safety checks. RN-A stated the licensee had considered a no trespass order if R2's boyfriend showed up to the home. RN-A confirmed that no interventions to protect R2 from threats made by the boyfriend were taken and they had not completed any assessments to see if R2 was being abused by the boyfriend.

On January 19, 2022, at approximately 11:50 a.m., ULP-C stated R2 had been having a lot of trouble with a guy and had a lot of emotional distress and expressed a plan to kill herself by taking a bunch of pills. ULP-C stated R2's boyfriend knew where she lived, and he said he might come by and destroy the property. ULP-C

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34760	A. BUILDING: _____ B. WING _____	01/19/2022

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03000	Continued From page 92 stated she had notified the nurse and was told she should increase the frequency of safety checks on R2 to every two hours. ULP-C stated the nurse did not implement any other interventions to protect R2 from self-harm or abuse from R2's boyfriend. ULP-C stated she did not know how to complete a MAARC report and did not think to file one in either situation. The licensee's undated Reporting Maltreatment of Vulnerable Adult policy indicated all facility personnel rendering service to a resident are mandated to report maltreatment or injuries to their supervisor or to MAARC. The policy indicated the facility would conduct an internal investigation for all reportable events No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03000		

Minnesota Department of Health
Environmental Health, FPLS
P.O Box 64975
St. Paul
651-201-4500

Type: Full
Date: *01/19/22*
Time: 13:10:24
Report: 8059221002

Food and Beverage Establishment Inspection Report

Location:
Paradise Assisted Living Inc
10829 Vincent Avenue South
Bloomington, MN55431
Hennepin County, 27

Establishment Info:
ID #: 0037501
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6124172373
ID #:

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

The following orders were issued during this inspection.

3-300B 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.

RAW SHELLED EGGS WERE BEING STORED OVER READY-TO-EAT FOOD. KEEP RAW SHELLED EGGS AND OTHER RAW ANIMAL FOODS BELOW READY-TO-EAT FOODS.

Comply By: 01/19/22

3-500C Microbial Control: date marking

3-501.17B ***** Priority 2 *****

MN Rule 4626.0400B Mark the refrigerated, ready-to-eat, TCS food prepared and packaged in a processing plant and opened and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded. The date must not exceed the manufacturer's use-by-date.

ESTABLISHMENT WAS NOT DATE MARKING AT READY-TO-EAT TCS FOODS. A FACT SHEET WAS SENT TOTHE ESTABLISHMENT.

Comply By: 01/19/22

7-100 Toxic Labeling

7-102.11 ***** Priority 2 *****

MN Rule 4626.1595 Clearly label all working containers used for storing poisonous or toxic materials from bulk supplies such as sanitizers and cleaners, with the common name of the product.

SPRAY BOTTLE WAS NOT LABELED WITH COMMON NAME OF THE PRODUCT.

Comply By: 01/19/22

Food and Beverage Establishment Inspection Report

2-100 Supervision

2-102.12AMN

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

NO CERTIFIED FOOD PROTECTION MANAGER IS EMPLOYED. A FACT SHEET WAS SENT TO THE ESTABLISHMENT.

Comply By: 02/19/22

4-200 Equipment Design and Construction

4-204.112D

MN Rule 4626.0620D Provide a temperature measuring device that is easily readable.

ESTABLISHMENT DOES NOT HAVE A THERMOMETER.

Comply By: 02/02/22

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

Violations werer reviewed with Barbara Axness, lead Nursing Evaluator, and Zuhur Ahmed, person in charge at Paradise Assisted Living.

The following was observed: laminate countertops, wood floor, hollow base cabinets, popcorn ceiling.

All dishes must be washed in the dishwasher on the sanitize setting.

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 8059221002 of 01/19/22.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Signed:_____
Establishment Representative

Signed:_____
James Noyola
Sanitarian Supervisor
St. Paul
651-201-4500
health.foodlodging@state.mn.us