



Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF REMOVAL OF CONDITIONAL LICENSE

Electronic Delivery

October 30, 2024

Licensee

Ultimate Care Assisted Living Spring Lake House
7931 6th Street Northeast
Spring Lake Park, MN 55432

RE: License Number 415172

Health Facility Identification Number (HFID) 33163

Project Number(s) SL33163015

Dear Licensee:

Please note, this letter amends the letter sent on October 23, 2024 and indicates the conditions imposed in the Notice of Conditional License issued on July 16, 2024 are removed.

On October 2, 2024, The Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed April 25, 2024, and the follow-up survey completed on July 2, 2024. This follow-up survey found the facility to be in substantial compliance. Based on these findings, the condition(s) on the license were removed effective October 23, 2024.

The Department of Health concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

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

Sincerely,

A handwritten signature in black ink that reads 'Rick Michals'.

Rick Michals, J.D.
Executive Regional Operations Manager
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64970
St. Paul, MN 55164-0970
Telephone: 651-201-4181 Fax: 651-215-9697

JMD



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

October 23, 2024

Licensee

Ultimate Care Assisted Living Spring Lake House
7931 6th Street Northeast
Spring Lake Park, MN 55432

RE: Project Number(s) SL33163015

Dear Licensee:

On October 2, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the April 25, 2024, survey were corrected. This follow-up survey verified that the facility is back in compliance.

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

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink that reads 'Kelly Thorson'.

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

JMD



Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF CONDITIONAL LICENSE

Electronically Delivered

July 16, 2024

Licensee

Ultimate Care Assisted Living Spring Lake House
7931 6th Street Northeast
Spring Lake Park, MN 55432

RE: Conditional License Number 415172
Health Facility Identification Number (HFID) 33163
Project Number(s) SL33163015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a follow-up survey on July 2, 2024, for the purpose of assessing compliance with state licensing statutes. Based on the follow-up survey results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, pursuant to Minn. Stat. § 144G.20, MDH is issuing a 90-day conditional license due to expire on **October 14, 2024**.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on April 25, 2024, found not corrected at the time of the July 2, 2024, follow-up survey and/or subject to penalty assessment are as follows:

0820 - Fire Protection And Physical Environment-144g.45 Subd. 2 - \$3,000.00

The details of the violations noted at the time of this follow-up survey completed on July 2, 2024 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$3,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

IMPOSITION OF FINES:

Level 1: no fines or enforcement.

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in §144G.20 for widespread violations;

Level 3: a fine of \$3,000 per violation per incident, in addition to any enforcement mechanism authorized in §144G.20.

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

To submit a reconsideration request, please visit:

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

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. to submit a hearing request, please visit:

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

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

CONDITIONAL LICENSE ISSUED:

MDH will issue Ultimate Care Assisted Living Spring Lake House a conditional assisted living facility license for 90 calendar days from the date of this notice. At an unannounced point in time, within the 90 calendar days, MDH will conduct a follow-up survey, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the follow-up survey, MDH will determine if Ultimate Care Assisted Living

Spring Lake House is in substantial compliance.

The following conditions apply on the conditional assisted living facility license:

- a. **Health Facility Construction Permit:** Ultimate Care Assisted Living Spring Lake House, will contact The Minnesota Department of Labor and Industry (MNDLI) or City with delegated authority to review and inspect State Licensed Facilities in accordance with Minn. Stat. § 326B.103, Subd. 13 and obtain a construction permit for a health facility. Within 21-days from the date of this notice, Ultimate Care Assisted Living Spring Lake House, will provide MDH with a copy of the permit obtained from MNDLI or City with delegated authority.
- b. **General Contractor:** Ultimate Care Assisted Living Spring Lake House must provide the following to Tim Hanna, (Tim.Hanna@state.mn.us) via email within 21-days of the date of this notice:
 - i. Name
 - ii. License Number
 - iii. Contact information
- c. **Egress Window Requirement:** Ultimate Care Assisted Living Spring Lake House will replace at least one window in occupied resident sleeping room #1, and meeting the minimum size requirements:
 - i. Must have a minimum openable width of no less than 20 inches.
 - ii. must have a minimum openable height of no less than 20 inches.
 - iii. Must have a total openable area of no less than 648 square inches (4.5 square feet).
 - iv. Must have a windowsill height of no more than 48 inches from the floor to the clear opening.
 - v. All measurements must be achieved under normal operation of opening window without the use of a key, tool or special knowledge.
- d. **Follow-up survey:** At the time of the follow-up survey, MDH may pursue additional enforcement actions, up to and including immediate temporary suspension or revocation of the license if MDH identifies any level 3 or 4 violations or widespread care related violations.

RESULTS OF FOLLOW-UP EVALUATION DURING THE CONDITIONAL LICENSE PERIOD:

MDH will determine if Ultimate Care Assisted Living Spring Lake House is in substantial compliance based on the results of the follow up survey. MDH will make this determination within the 90-day conditional license period. If MDH determines Ultimate Care Assisted Living Spring Lake House is in substantial compliance on the follow up survey, MDH will remove the conditions from Ultimate Care

Assisted Living Spring Lake House's assisted living facility license, and Ultimate Care Assisted Living Spring Lake House will correct any outstanding violations identified during the survey. If Ultimate Care Assisted Living Spring Lake House is not in substantial compliance on the follow-up survey, MDH may take additional enforcement action, up to and including immediate temporary suspension and revocation, as authorized by Minn. Stat. § 144G.20.

REQUESTING A HEARING:

Pursuant to Minn. Stat. §144G.20, Subd. 18, the licensee may appeal an action against the license under this section. The licensee must request a hearing no later than 15 business days after licensee receives notice of the action. To submit a hearing request, please visit <https://forms.web.health.state.mn.us/form/HRD-Appeals-Form>.

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

If you have any questions, please contact Kelly Thorson directly at: 320-223-7336.

Sincerely,

A handwritten signature in black ink that reads "Rick Michals". The signature is written in a cursive, slightly slanted style.

Rick Michals, J.D.

Interim Assistant Division Director

**Minnesota Department of Health
Health Regulation Division**

AH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33163	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 07/02/2024
NAME OF PROVIDER OR SUPPLIER ULTIMATE CARE ASSISTED LIVING SPRING LAKE HOUSE			STREET ADDRESS, CITY, STATE, ZIP CODE 7931 6TH STREET NE SPRING LAKE PARK, MN 55432		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
{0 000}	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL33163015-1 On July 1, 2024 through July 2, 2024, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on April 25, 2024. At the time of the survey, there were 3 residents; 3 receiving services under the Assisted Living license. As a result of the follow-up survey, the following orders were reissued.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
{0 820} SS=I	144G.45 Subd. 2 (g) Fire protection and physical environment	{0 820}			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33163	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 07/02/2024
NAME OF PROVIDER OR SUPPLIER ULTIMATE CARE ASSISTED LIVING SPRING L			STREET ADDRESS, CITY, STATE, ZIP CODE 7931 6TH STREET NE SPRING LAKE PARK, MN 55432		
(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	
{0 820}	Continued From page 1 (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide an egress window that met the minimum width opening requirement in an occupied resident bedroom. This had the potential to directly affect one resident and all staff. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On July 1, 2024, during a follow-up onsite revisit, at 1:20 p.m., survey staff toured bedroom one with licensed assisted living director (LALD)-A.	{0 820}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33163	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 07/02/2024
NAME OF PROVIDER OR SUPPLIER ULTIMATE CARE ASSISTED LIVING SPRING L			STREET ADDRESS, CITY, STATE, ZIP CODE 7931 6TH STREET NE SPRING LAKE PARK, MN 55432		
(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
{0 820}	Continued From page 2 The sliding egress window in bedroom one, which was occupied by a resident, had not been replaced and the opening measured 12.75 inches in width, and 48 inches in height, with a total clear open area of 612 square inches. The egress window in bedroom one did not meet the minimum opening requirements of at least 20 inches in width and a total clear area of 648 square inches. LALD-A popped both window slides out, the opening then measured 31 inches in width, and 48 inches in height, with a total clear open area of 1488 square inches. During an interview on July 1, 2024, at 1:20 p.m., LALD-A stated the owner of the home had showed him how to easily take the windows out, which then made the opening of the window in compliance with the measurement requirements. LALD-A stated he had not verified this fix with a state engineer. TIME PERIOD FOR CORRECTION: IMMEDIATE	{0 820}			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

May 29, 2024

Licensee

Ultimate Care Assisted Living Spring Lake House
7931 6th Street Northeast
Spring Lake Park, MN 55432

RE: Project Number(s) SL33163015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 25, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;

Level 3: a fine of \$3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.

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

In accordance with Minn. Stat. § 144G.31, Subd. 4(a)(5), MDH may impose fine amounts of either \$1,000 or \$5,000 to licensees who are found to be responsible for maltreatment. MDH may impose a fine of \$1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. MDH also may impose a

fine of \$5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this survey:

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

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$3,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

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

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a

hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. to submit a hearing request, please visit:

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

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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **<https://forms.office.com/g/Bm5uQEPhVa>**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,



Kelly Thorson, Supervisor

State Evaluation Team

Email: kelly.thorson@state.mn.us

Telephone: 320-223-7336 Fax: 1-866-890-9290

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33163	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/25/2024
NAME OF PROVIDER OR SUPPLIER ULTIMATE CARE ASSISTED LIVING SPRING L			STREET ADDRESS, CITY, STATE, ZIP CODE 7931 6TH STREET NE SPRING LAKE PARK, MN 55432		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL33163015-0 On April 22, 2024, through April 25, 2024, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were three residents; three receiving services under the provider's Assisted Living license. An immediate correction order was identified on April 23, 2024, issued for SL33163015-0, tag identification 2310. The immediacy of correction order 2310 was not removed prior to the exit of the survey on April 25, 2024.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.		
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a	0 250			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33163	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/25/2024
NAME OF PROVIDER OR SUPPLIER ULTIMATE CARE ASSISTED LIVING SPRING L		STREET ADDRESS, CITY, STATE, ZIP CODE 7931 6TH STREET NE SPRING LAKE PARK, MN 55432			
(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
0 250	Continued From page 1 provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter;	0 250			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33163	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/25/2024
NAME OF PROVIDER OR SUPPLIER ULTIMATE CARE ASSISTED LIVING SPRING L			STREET ADDRESS, CITY, STATE, ZIP CODE 7931 6TH STREET NE SPRING LAKE PARK, MN 55432		
(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
0 250	Continued From page 2 (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the management officials who were in charge of the day-to-day operations; and responsible for the resident's assisted living services, understood all of the assisted living facility regulations. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a 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: During the entrance conference on April 22, 2024, at 1:30 p.m., licensed assisted living director (LALD)-A stated they were familiar with the	0 250			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33163	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/25/2024
NAME OF PROVIDER OR SUPPLIER ULTIMATE CARE ASSISTED LIVING SPRING L			STREET ADDRESS, CITY, STATE, ZIP CODE 7931 6TH STREET NE SPRING LAKE PARK, MN 55432		
(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
0 250	Continued From page 3 current assisted living laws and regulations. The licensee's "Application for Assisted Living License", section titled "Official Verification of Owner or Authorized Agent", (page five of the application), identified, "I certify I have read and understand the following:" [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45 (opens in a new window), my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17 (opens in a new window). - I have read and fully understand Minn. Stat. sect. 144G.80 (opens in a new window), 144G.81 (opens in a new window). and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22 (opens in a new window), my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G (opens in a new window). - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659 (proposed and not final) (opens in a new window). - Reporting of Maltreatment of Vulnerable Adults (opens in a new window). - Electronic Monitoring in Certain Facilities (opens in a new window). - I understand pursuant to Minn.Stat. sect. 13.04 Rights of Subjects of Data (opens in a new window), the Commissioner will use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets the requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or	0 250			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33163	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/25/2024
NAME OF PROVIDER OR SUPPLIER ULTIMATE CARE ASSISTED LIVING SPRING L			STREET ADDRESS, CITY, STATE, ZIP CODE 7931 6TH STREET NE SPRING LAKE PARK, MN 55432		
(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	
0 250	Continued From page 4 misleading information may delay the processing of my application or maybe grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license. - I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G (opens in a new window), and Minnesota Rules, chapter 4659 (proposed and not final) (opens in a new window), governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. - I have examined this application and all attachments, and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct and complete. I will notify MDH, in writing, of any changes to this information as required.	0 250			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33163	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/25/2024
NAME OF PROVIDER OR SUPPLIER ULTIMATE CARE ASSISTED LIVING SPRING L			STREET ADDRESS, CITY, STATE, ZIP CODE 7931 6TH STREET NE SPRING LAKE PARK, MN 55432		
(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	
0 250	Continued From page 5 - I attest to have all required policies and procedures of Minn. Stat. chapter 144G (opens in new window). and Minn. Rules chapter 4659 (opens in new window), in place upon licensure and to keep them current as applicable. - I attest that the assisted living facility has provided services to at least one resident during the immediately preceding license year as required by Minn. Stat. sect. 144G.17 (5) (opens in a new window). Page six was electronically signed by the authorized agent on December 19, 2023. The licensee had an assisted living license, effective February 1, 2024. The licensee failed to ensure the following policies and procedures were developed and/or implemented: - orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; - conducting and handling background studies on employees; - orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; - conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; right now - orientation to implementation of the assisted living Bill of Rights; - conducting appropriate screenings, or documentation of prior screenings, to show that staff were free of tuberculosis, consistent with	0 250			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33163	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/25/2024
NAME OF PROVIDER OR SUPPLIER ULTIMATE CARE ASSISTED LIVING SPRING L			STREET ADDRESS, CITY, STATE, ZIP CODE 7931 6TH STREET NE SPRING LAKE PARK, MN 55432		
(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
0 250	Continued From page 6 current United States Centers for Disease Control and Prevention of Standards; - medication and treatment management. As a result of the survey, the following correction orders were issued, 0330, 0480, 0630, 0660, 0680, 0780, 0810, 0820, 0910, 0920, 0930, 0940, 0950, 1290, 1370, 1380, 1470, 1500, 1530, 1620, 1650, 1730, 1770, 1880, 1940, and 2310, which indicated the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.01 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250			
0 330 SS=D	144G.30 Subd. 4 Information provided by facility (a) The assisted living facility shall provide accurate and truthful information to the department during a survey, investigation, or other licensing activities. (b) Upon request of a surveyor, assisted living facilities shall within a reasonable period of time provide a list of current and past residents and their legal representatives and designated representatives that includes addresses and telephone numbers and any other information requested about the services to residents. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide accurate and truthful information for one of one medication refrigeration temperature logs.	0 330			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33163	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/25/2024
NAME OF PROVIDER OR SUPPLIER ULTIMATE CARE ASSISTED LIVING SPRING L			STREET ADDRESS, CITY, STATE, ZIP CODE 7931 6TH STREET NE SPRING LAKE PARK, MN 55432		
(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	
0 330	Continued From page 7 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: On April 22, 2024, at 2:00 p.m., the surveyor observed the assisted living medication refrigerator with licensed assisted living director (LALD)-A which contained six unopened Basaglar insulin pens for R3. No temperature log for April 2024 was noted. LALD-A stated the temperature log was kept in a folder for staff to document the temperature reading in and would get the log for the surveyor. On April 23, 2024, at 2:30 p.m., the surveyor received four identical temperature logs for January, February, March, and April 2024. All four logs had the dates listed as one through thirty-one and every box on the sheet was filled in. The log identified columns labeled kitchen fridge, freezer, and medication fridge with boxes to write in both an AM and PM temperature reading, all boxes were filled in with various temperature readings from 33°F to 46°F. On April 23, 2024, at 2:30 p.m., LALD-A stated the temperature logs provided were not accurate because all four months were identical and appeared to be copies with a different month listed on the top of the log. LALD-A agreed the staff were not logging the medication refrigerator temperature as they were trained to. LALD-A	0 330			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33163	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/25/2024
NAME OF PROVIDER OR SUPPLIER ULTIMATE CARE ASSISTED LIVING SPRING L			STREET ADDRESS, CITY, STATE, ZIP CODE 7931 6TH STREET NE SPRING LAKE PARK, MN 55432		
(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
0 330	Continued From page 8 agreed the month of February does not have thirty-one days and that it is currently April 23 and so the boxes for the remainder of the month should not already be filled in yet. No further information provided. TIME PERIOD FOR CORRECTION: Two (2) Days	0 330			
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated April 22, 2024 for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24	0 480			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33163	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/25/2024
NAME OF PROVIDER OR SUPPLIER ULTIMATE CARE ASSISTED LIVING SPRING L			STREET ADDRESS, CITY, STATE, ZIP CODE 7931 6TH STREET NE SPRING LAKE PARK, MN 55432		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
0 480	Continued From page 9 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the 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) included specific measures to be taken to minimize the risk of abuse for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include:	0 630			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33163	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/25/2024
NAME OF PROVIDER OR SUPPLIER ULTIMATE CARE ASSISTED LIVING SPRING L			STREET ADDRESS, CITY, STATE, ZIP CODE 7931 6TH STREET NE SPRING LAKE PARK, MN 55432		
(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	
0 630	Continued From page 10 R1's IAPP dated March 11, 2024, did not include specific measures to be taken to minimize the risk of abuse. On April 24, 2024, at 2:50 p.m., clinical nurse supervisor (CNS)-B stated interventions to minimize the risk of abuse were missing from R1's IAPP and was not sure why they were missing. CNS-B further stated they use the same forms for all the residents. The licensee's Comprehensive Nursing Assessment policy dated February 17, 2022, indicated the registered nurse will complete a comprehensive nursing assessment which will include a vulnerability assessment. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630			
0 660 SS=F	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			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33163	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/25/2024
NAME OF PROVIDER OR SUPPLIER ULTIMATE CARE ASSISTED LIVING SPRING L			STREET ADDRESS, CITY, STATE, ZIP CODE 7931 6TH STREET NE SPRING LAKE PARK, MN 55432		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
0 660	Continued From page 11 the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC). The licensee failed to ensure screening for active TB (either a two-step tuberculin skin test (TST) or blood test) were completed and documented for two of two employees, (clinical nurse supervisor (CNS)-B 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, 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: CNS-B CNS-B was hired on January 11, 2024, to provide supervision and oversight to unlicensed personnel and to provide direct services to residents. On April 23, 2024, at 10:00 a.m., the surveyor observed CNS-B working for the licensee and gathering paperwork the surveyor requested. CNS-B's employee record contained a TB	0 660			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33163	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/25/2024
NAME OF PROVIDER OR SUPPLIER ULTIMATE CARE ASSISTED LIVING SPRING L			STREET ADDRESS, CITY, STATE, ZIP CODE 7931 6TH STREET NE SPRING LAKE PARK, MN 55432		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 660	Continued From page 12 QuantiFERON Gold blood test dated November 23, 2020, greater than 90 days prior to CNS-B's hire date. ULP-C ULP-C was hired on March 21, 2023, to perform direct care services to the licensee's residents. On April 24, 2024, at 12:15 p.m., the surveyor observed ULP-C administer medications to R1 via gastrostomy tube. ULP-C's record contained a negative chest x-ray dated July 14, 2022. ULP-C's record lacked evidence of a TB baseline screening that had been completed at the time of hire to indicate the need for the chest x-ray. On April 24, 2024, at 3:35 p.m., the licensed assisted living director (LALD)-A stated CNS-B's TB test was not within the 90-day time frame prior to hire and would need to get a new negative TB test for her employee record. LALD-A stated ULP-C's record only contained the negative chest x-ray and they did not have evidence of the positive two-step TB test or other blood test that would indicate the need for the chest x-ray. LALD-A stated they were not aware of these specific requirements for TB testing for employees until the surveyor had explained them and thought the negative TB tests, they had for both employees met the requirement. The licensee's Tuberculosis Screening/Prevention policy dated February 17, 2022, indicated the licensee will observe the recommended precautions related to TB prevention as identified by the CDC and the MDH. The precautions include the following elements:	0 660			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33163	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/25/2024
NAME OF PROVIDER OR SUPPLIER ULTIMATE CARE ASSISTED LIVING SPRING L			STREET ADDRESS, CITY, STATE, ZIP CODE 7931 6TH STREET NE SPRING LAKE PARK, MN 55432		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 660	Continued From page 13 - Risk assessment; - TB screening; and - Staff education. The CDC TB Screening and Testing of Health Care Personnel, updated August 30, 2022, indicated all United States health care personnel should be screened for TB upon hire. TB screening is a process that includes: - A baseline individual TB Risk assessment; - TB symptom evaluation; and - Additional evaluation for TB disease as needed. The MDH guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines, indicated an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The MDH resources and frequently asked questions, updated April 3, 2024, indicated a chest x-ray alone is not acceptable documentation. You either need: - Documentation of a positive two-step TST or IGRA test, and - A chest x-ray with provider evaluation after that date or - Documentation of refusal of both the two-step TST and IGRA - Followed by a new chest X-ray and provider evaluation. If the health care worker had a positive TB test result, and they only have the chest X-ray but no other test documentation, then they need to take a new TB test. If the result is positive, a new chest X-ray needs to be completed. The chest	0 660			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33163	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/25/2024
NAME OF PROVIDER OR SUPPLIER ULTIMATE CARE ASSISTED LIVING SPRING L			STREET ADDRESS, CITY, STATE, ZIP CODE 7931 6TH STREET NE SPRING LAKE PARK, MN 55432		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 660	Continued From page 14 X-ray needs to be done within 90 days of the positive test date or dated any time after the positive test date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced	0 680			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33163	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/25/2024
NAME OF PROVIDER OR SUPPLIER ULTIMATE CARE ASSISTED LIVING SPRING L			STREET ADDRESS, CITY, STATE, ZIP CODE 7931 6TH STREET NE SPRING LAKE PARK, MN 55432		
(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 15 by: Based on interview and record review, the licensee failed to have a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all visitors, employees, and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 the residents). The findings include: The licensee's undated EPP lacked documentation including all the required elements of: -annual review -quarterly review of missing resident policy -procedures for tracking of staff and patients -policies and procedures for volunteers -name and contact information -sharing information on occupancy/needs On April 25, 2024, at 2:00 p.m., licensed assisted living director (LALD)-A stated the contact information for the residents and their physicians are in the resident emergency folder which the staff would take with them in the event of an evacuation. They do not have volunteers, so they do not have a policy regarding volunteers. They do not have a policy or procedure for tracking or for occupancy/needs. LALD-A stated he was not aware of that requirement. LALD-A further stated	0 680			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33163	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/25/2024
NAME OF PROVIDER OR SUPPLIER ULTIMATE CARE ASSISTED LIVING SPRING L		STREET ADDRESS, CITY, STATE, ZIP CODE 7931 6TH STREET NE SPRING LAKE PARK, MN 55432			
(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 16 they have not reviewed the EPP annually nor have they reviewed the missing persons policy quarterly as he was not aware of this requirement. The licensee's Emergency Preparedness policy dated February 17, 2022, indicated [the facility] will have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services. The emergency preparedness plan/program will be reviewed/updated at least annually. The licensee's Missing Resident policy dated February 17, 2022, indicated the missing resident procedure will be reviewed by the director and clinical nurse supervisor at least quarterly. No further information 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	0 780			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33163	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/25/2024
NAME OF PROVIDER OR SUPPLIER ULTIMATE CARE ASSISTED LIVING SPRING L			STREET ADDRESS, CITY, STATE, ZIP CODE 7931 6TH STREET NE SPRING LAKE PARK, MN 55432		
(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
0 780	Continued From page 17 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 interconnected smoke alarms that complied with fire protection requirements. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On April 22, 2024, at 2:00 p.m., survey staff toured the home with licensed assisted living director (LALD)-A. During the tour, survey staff observed when smoke alarms were tested none of the other smoke alarms in the home were activated. The smoke alarms installed in the dwelling unit were not interconnected. During an	0 780			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33163	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/25/2024
NAME OF PROVIDER OR SUPPLIER ULTIMATE CARE ASSISTED LIVING SPRING L			STREET ADDRESS, CITY, STATE, ZIP CODE 7931 6TH STREET NE SPRING LAKE PARK, MN 55432		
(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	
0 780	Continued From page 18 interview on April 24, 2024, at 3:00 p.m., LALD-A verified the smoke alarms were not interconnected. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780			
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33163	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/25/2024
NAME OF PROVIDER OR SUPPLIER ULTIMATE CARE ASSISTED LIVING SPRING L			STREET ADDRESS, CITY, STATE, ZIP CODE 7931 6TH STREET NE SPRING LAKE PARK, MN 55432		
(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	
0 810	Continued From page 19 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 record review and interview, the licensee failed to develop a fire safety and evacuation plan with the required content, and provide required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On April 22, 2024, at 12:38 p.m., survey staff emailed the licensee requesting the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and employee evacuation drills for the facility with a deadline of April 24, 2024, at 9:00 a.m. On April 24, 2024, at 2:30 p.m., survey staff emailed the licensee requesting the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and employee evacuation drills for the facility with a deadline of April 24, 2024, at 11:00 p.m., as this information had not been received. During an interview on April 24, 2024, at 3:00 p.m., licensed assisted living	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33163	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/25/2024
NAME OF PROVIDER OR SUPPLIER ULTIMATE CARE ASSISTED LIVING SPRING L			STREET ADDRESS, CITY, STATE, ZIP CODE 7931 6TH STREET NE SPRING LAKE PARK, MN 55432		
(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
0 810	Continued From page 20 director (LALD)-A stated this documentation would be emailed to survey staff by 11:00 p.m. on April 24, 2024. On April 25, 2024, at 10:07 a.m., LALD-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and employee evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The FSEP included fire safety and emergency preparedness policies both dated February 17, 2022. The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. Employee actions for fire were limited to the acronym RACE (Remove, Alarm, Confine, and Extinguish or Evacuate). The FSEP failed to identify fire protection procedures necessary for residents evident by limited instructions directing residents to stoop or crawl to avoid smoke. The FSEP failed to provide specific procedures for resident movement, evacuation, and relocation during a fire or similar emergency including the unique needs of residents evident by a lack of these procedures in the plan. The documentation included a resident priority classification indicating residents would require employee assistance during an evacuation. During an interview on April 24, 2024, at 3:00 p.m., LALD-A stated the FSEP was stored in a	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33163	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/25/2024
NAME OF PROVIDER OR SUPPLIER ULTIMATE CARE ASSISTED LIVING SPRING L			STREET ADDRESS, CITY, STATE, ZIP CODE 7931 6TH STREET NE SPRING LAKE PARK, MN 55432		
(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
0 810	Continued From page 21 binder and would be emailed to survey staff by 11:00 p.m., on April 24, 2024. On April 25, 2024, at 10:07 a.m., the licensed assisted living director (LALD)-A emailed the FSEP to survey staff. TRAINING Record review indicated the licensee failed to provide training to employees on the FSEP upon hire and/or at least twice per year as evident by the lack of training documentation. Emergency preparedness training records were provided dated 2023. During an interview on April 24, 2024, at 3:00 p.m., LALD-A stated employees were trained on the FSEP during fire drills and at the time of hire, but this had not been documented separately. Records had not been created to document employee FSEP training. Record review indicated the licensee failed to provide fire safety and evacuation training to residents at least once per year as evident by the lack of training documentation. Emergency preparedness training records were provided dated 2023. During an interview on April 24, 2024, at 3:00 p.m., LALD-A stated residents were trained on fire safety and evacuation when they moved in and then quarterly but this had not been documented separately. Records had not been created to document resident training on fire safety and evacuation. DRILLS Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift as evident by fire drill reports lacking the required shift frequency. The time or shift was not recorded on the 2023 and 2024 fire drill logs. During an interview on April 24, 2024, at 3:00 p.m., LALD-A explained the fire drill frequency was every two months and stated drill	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33163	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/25/2024
NAME OF PROVIDER OR SUPPLIER ULTIMATE CARE ASSISTED LIVING SPRING L			STREET ADDRESS, CITY, STATE, ZIP CODE 7931 6TH STREET NE SPRING LAKE PARK, MN 55432		
(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	
0 810	Continued From page 22 records would be emailed to survey staff by 11:00 p.m. on April 24, 2024. Fire drill records were received on April 25, 2024, at 10:07 a.m., but these records did not support the evacuation drill frequency requirement of twice per year per shift. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
0 820 SS=D	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide a resident bedroom with the minimum window opening meeting the minimum state standard for egress. This had the potential to directly affect one resident and all 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	0 820			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33163	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/25/2024
NAME OF PROVIDER OR SUPPLIER ULTIMATE CARE ASSISTED LIVING SPRING L			STREET ADDRESS, CITY, STATE, ZIP CODE 7931 6TH STREET NE SPRING LAKE PARK, MN 55432		
(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
0 820	Continued From page 23 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: On April 22, 2024, at 2:00 p.m., survey staff toured the home with licensed assisted living director (LALD)-A. During the tour egress windows in resident bedrooms were opened and measured. The egress window in bedroom one did not meet the minimum opening requirements for width and total clear area. The egress window in bedroom one measured 12.75 inches in width, and 48 inches in height, with a total clear open area of 612 square inches. The egress window in bedroom one did not meet the minimum opening requirements of at least 20 inches in width and a total clear area of 648 square inches. One window in each resident bedroom must meet the minimum window opening size of 20 inches in width and, a minimum height of 20 inches, with a total of at least 648 square inches (4.5 square feet). During an interview on April 24, 2024, at 3:00 p.m., LALD-A verified the egress window measurements and stated bedroom one would not be occupied by a resident until a new window was installed. TIME PERIOD FOR CORRECTION: Seven (7) Days	0 820			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33163	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/25/2024
NAME OF PROVIDER OR SUPPLIER ULTIMATE CARE ASSISTED LIVING SPRING L			STREET ADDRESS, CITY, STATE, ZIP CODE 7931 6TH STREET NE SPRING LAKE PARK, MN 55432		
(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
0 910	Continued From page 24	0 910			
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for one of one resident (R1). 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). The findings include: R1's Assisted Living Contract was signed by R1 November 30, 2023. R1's contract did not include: -health facility identification of the facility. -telephone number, and physical mailing address,	0 910			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33163	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/25/2024
NAME OF PROVIDER OR SUPPLIER ULTIMATE CARE ASSISTED LIVING SPRING L			STREET ADDRESS, CITY, STATE, ZIP CODE 7931 6TH STREET NE SPRING LAKE PARK, MN 55432		
(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
0 910	Continued From page 25 which may not be a public or private post office box, of: -the facility and contracted service provider when applicable -the licensee of the facility -the managing agent of the facility, if applicable On April 25, 2024, at 11:10 a.m., licensed assisted living director (LALD)-A stated they may not be aware of all the required contents of the resident contract. LALD-A agreed the current resident contract was missing the required information per the statutes because they are using an old contract template that has not been updated. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 910			
0 920 SS=C	144G.50 Subd. 2 (c) Contract information (c) The contract must include: (1) a disclosure of the category of assisted living facility license held by the facility and, if the facility is not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license; (2) a description of all the terms and conditions of the contract, including a description of and any limitations to the housing or assisted living services to be provided for the contracted amount; (3) a delineation of the cost and nature of any other services to be provided for an additional fee; (4) a delineation and description of any additional fees the resident may be required to pay if the	0 920			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33163	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/25/2024
NAME OF PROVIDER OR SUPPLIER ULTIMATE CARE ASSISTED LIVING SPRING L			STREET ADDRESS, CITY, STATE, ZIP CODE 7931 6TH STREET NE SPRING LAKE PARK, MN 55432		
(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	
0 920	Continued From page 26 resident's condition changes during the term of the contract; (5) a delineation of the grounds under which the resident may be transferred or have housing or services terminated or be subject to an emergency relocation; (6) billing and payment procedures and requirements; and (7) disclosure of the facility's ability to provide specialized diets. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have all required content in the contract for one of one resident (R1). 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). The findings include: R1's Assisted Living Contract was signed by R1 November 30, 2023. R1's contract failed to include the following required content: -a disclosure of the category of assisted living facility license held by the facility and, if the facility is not an assisted living with dementia care, a disclosure that it does not hold an assisted living with dementia care license On April 25, 2024, at 11:10 a.m., licensed	0 920			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33163	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/25/2024
NAME OF PROVIDER OR SUPPLIER ULTIMATE CARE ASSISTED LIVING SPRING L			STREET ADDRESS, CITY, STATE, ZIP CODE 7931 6TH STREET NE SPRING LAKE PARK, MN 55432		
(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
0 920	Continued From page 27 assisted living director (LALD)-A stated they may not be aware of all the required contents of the resident contract. LALD-A agreed the current resident contract was missing the required information per the statutes because they are using an old contract template that has not been updated. LALD-A stated the cost of services provided was was not listed in the contract due to all of the current residents are on elderly waiver and he has not had any private pay residents, so the cost of services not been needed. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 920			
0 930 SS=C	144G.50 Subd. 2 (d-e; 1-4) Contract information (d) The contract must include a description of the facility's complaint resolution process available to residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints. (e) The contract must include a clear and conspicuous notice of: (1) the right under section 144G.54 to appeal the termination of an assisted living contract; (2) the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer; (3) contact information for the Office of Ombudsman for Long-Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints;	0 930			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33163	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/25/2024
NAME OF PROVIDER OR SUPPLIER ULTIMATE CARE ASSISTED LIVING SPRING LAKE			STREET ADDRESS, CITY, STATE, ZIP CODE 7931 6TH STREET NE SPRING LAKE PARK, MN 55432		
(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
0 930	Continued From page 28 (4) the resident's right to obtain services from an unaffiliated service provider; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for one of one resident (R1). 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). The findings include: R1's Assisted Living Contract was signed by R1 November 30, 2023. R1's contract failed to include the following required content: -the right under section 144G.54 to appeal the termination of an assisted living contract -the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer -the resident's right to obtain services from an unaffiliated service provider On April 25, 2024, at 11:10 a.m., licensed assisted living director (LALD)-A stated they may not be aware of all the required contents of the resident contract. LALD-A agreed the current resident contract was missing the required information per the statutes because they are using an old contract template that has not been	0 930			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33163	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/25/2024
NAME OF PROVIDER OR SUPPLIER ULTIMATE CARE ASSISTED LIVING SPRING L			STREET ADDRESS, CITY, STATE, ZIP CODE 7931 6TH STREET NE SPRING LAKE PARK, MN 55432		
(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
0 930	Continued From page 29 updated. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 930			
0 940 SS=C	144G.50 Subd. 2 (e; 5-7) Contract information (5) a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: (i) whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; (ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); (iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; (iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; (v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; (vi) a statement that residents may be eligible for assistance with rent through the housing support program; and (vii) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance	0 940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33163	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/25/2024
NAME OF PROVIDER OR SUPPLIER ULTIMATE CARE ASSISTED LIVING SPRING L			STREET ADDRESS, CITY, STATE, ZIP CODE 7931 6TH STREET NE SPRING LAKE PARK, MN 55432		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 940	Continued From page 30 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 one of one resident (R1). 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). The findings include: R1's Assisted Living Contract was signed by R1 November 30, 2023. R1's contract failed to include the following required content: -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: -whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers -whether the facility has an agreement to provide	0 940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33163	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/25/2024
NAME OF PROVIDER OR SUPPLIER ULTIMATE CARE ASSISTED LIVING SPRING L			STREET ADDRESS, CITY, STATE, ZIP CODE 7931 6TH STREET NE SPRING LAKE PARK, MN 55432		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
0 940	Continued From page 31 housing support under section 256I.04, subdivision 2, paragraph (b) - whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided. -whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required - a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent - a statement that residents may be eligible for assistance with rent through the housing support program - 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. -the contact information to obtain long-term care consulting services under section 256B.0911 -the toll-free number for the Minnesota Adult Abuse Reporting Center On April 25, 2024, at 11:10 a.m., licensed assisted living director (LALD)-A stated they may not be aware of all the required contents of the resident contract. LALD-A agreed the current resident contract was missing the required information per the statutes because they are using an old contract template that has not been updated. LALD-A stated the contract did not include information about financial assistance programs due to all of the residents are on elderly waiver and he has not had any private pay residents.	0 940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33163	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/25/2024
NAME OF PROVIDER OR SUPPLIER ULTIMATE CARE ASSISTED LIVING SPRING L			STREET ADDRESS, CITY, STATE, ZIP CODE 7931 6TH STREET NE SPRING LAKE PARK, MN 55432		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
0 940	Continued From page 32 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 940			
0 950 SS=C	144G.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	0 950			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33163	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/25/2024
NAME OF PROVIDER OR SUPPLIER ULTIMATE CARE ASSISTED LIVING SPRING L			STREET ADDRESS, CITY, STATE, ZIP CODE 7931 6TH STREET NE SPRING LAKE PARK, MN 55432		
(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	
0 950	Continued From page 33 by: Based on interview and record review, the licensee failed to offer the resident the opportunity to identify a designated representative in writing with the required statutory language for one of one resident (R1). 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). The findings include: R1's Assisted Living Contract was signed by R1 November 30, 2023. R1's assisted living contract failed to include statute statement from 144.50 subd. 3 with required verbatim 'right to designate a representative for certain purposes' on a separate page in the contract. On April 25, 2024, at 11:10 a.m., licensed assisted living director (LALD)-A stated they may not be aware of all the required contents of the resident contract. LALD-A agreed the current resident contract was missing the required information per the statutes because they are using an old contract template that has not been updated. LALD-A stated the contract did not include a place for the residents to designate a representative. No further information was provided.	0 950			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33163	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/25/2024
NAME OF PROVIDER OR SUPPLIER ULTIMATE CARE ASSISTED LIVING SPRING L			STREET ADDRESS, CITY, STATE, ZIP CODE 7931 6TH STREET NE SPRING LAKE PARK, MN 55432		
(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	
0 950	Continued From page 34	0 950			
	TIME PERIOD FOR CORRECTION: Twenty-One (21) days				
01290 SS=D	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure current employee records contained all the required content to include a background study clearance letter with the correct affiliation healthcare facility identification number (HFID) for the assisted living facility for one of two employees (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, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a	01290			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33163	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/25/2024
NAME OF PROVIDER OR SUPPLIER ULTIMATE CARE ASSISTED LIVING SPRING L			STREET ADDRESS, CITY, STATE, ZIP CODE 7931 6TH STREET NE SPRING LAKE PARK, MN 55432		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01290	Continued From page 35 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 on March 21, 2023, to perform direct care services to the licensee's residents. On April 24, 2024, at 12:15 p.m., the surveyor observed ULP-C administer medications to R1 via gastrostomy tube. ULP-C's record contained a background study dated November 4, 2022, the study indicated ULP-C was cleared, however, the background study was affiliated with HFID 29624, and not the assisted living HFID 33163. ULP-C's record also contained a background study dated April 22, 2024, the study indicated ULP-C was cleared, however, the background study was not initiated and completed prior to the start of the survey. On April 23, 2024, at 3:35 p.m., licensed assisted living director (LALD)-A stated they had completed the background study for ULP-C on the day the survey began when they had realized ULP-C was only been affiliated with the HFID 29624. LALD-A stated the HFID 29624 is the facility ULP-C had started at and they had forgotten to complete a background study for this HFID. The licensee's Personnel Records policy dated February 17, 2022, indicated at a minimum, all documents related to the following are kept in the personnel record, as applicable to job requirements: - Evidence of current professional licensure, registration or certification	01290			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33163	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/25/2024
NAME OF PROVIDER OR SUPPLIER ULTIMATE CARE ASSISTED LIVING SPRING L			STREET ADDRESS, CITY, STATE, ZIP CODE 7931 6TH STREET NE SPRING LAKE PARK, MN 55432		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
01290	Continued From page 36 - Results of background studies; - Records of annual training and infection control training; - Documentation of orientation; - Documentation of supervision, as applicable; - Performance reviews; - Competency evaluations; - Signed job description; and - Documentation of annual performance reviews identifying areas of improvement needed and training needs. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290			
01370 SS=D	144G.61 Subd. 2 (a) 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; (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	01370			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33163	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/25/2024
NAME OF PROVIDER OR SUPPLIER ULTIMATE CARE ASSISTED LIVING SPRING L			STREET ADDRESS, CITY, STATE, ZIP CODE 7931 6TH STREET NE SPRING LAKE PARK, MN 55432		
(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
01370	Continued From page 37 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 evaluations for the required topics were completed by one of one unlicensed personnel (ULP-C) prior to providing direct cares. 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:	01370			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33163	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/25/2024
NAME OF PROVIDER OR SUPPLIER ULTIMATE CARE ASSISTED LIVING SPRING L			STREET ADDRESS, CITY, STATE, ZIP CODE 7931 6TH STREET NE SPRING LAKE PARK, MN 55432		
(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
01370	Continued From page 38 ULP-C was hired on March 21, 2023, to perform direct care services to the licensee's residents. On April 24, 2024, at 12:15 p.m., the surveyor observed ULP-C administer medications to R1 via gastrostomy tube. ULP-C's record lacked evidence of training prior to providing services for the following: - documentation requirements for all services provided; - care and use of hearing aids; - standby assistance techniques and how to perform them; - medication, exercise, and treatment reminders; - preparation of modified diets as ordered by a licensed health professional; and - awareness of commonly used health technology equipment and assistive devices. On April 24, 2024, at 3:35 p.m. Licensed assisted living director (LALD)-A agreed that ULP-C's employee record was missing some of the required training and competency topics. LALD-A stated a different nurse that was no longer employed by the licensee completed the training and competency and they did not realize some topics were missing. The licensee's Staff Competency policy dated February 17, 2022, indicated training and competency evaluations for all unlicensed personnel include the following: - documentation requirements for all services provided; - reports of changes in the residence condition to the supervisor designated by the assisted living provider; - basic infection control, including blood-borne pathogens;	01370			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33163	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/25/2024
NAME OF PROVIDER OR SUPPLIER ULTIMATE CARE ASSISTED LIVING SPRING L			STREET ADDRESS, CITY, STATE, ZIP CODE 7931 6TH STREET NE SPRING LAKE PARK, MN 55432		
(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	
01370	Continued From page 39 - 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 for providers working with the elderly or those at risk of falls; - standby assistance techniques and how to perform them; - medication, exercise and treatment reminders; - basic nutrition, meal preparation and preparation of modified diets as ordered by a licensed health professional, food safety and assistance with eating; - 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, residents and the resident's family; - procedures to utilize in handling various emergency situations; and - awareness of commonly used health technology equipment and assistive devices. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370			
01380 SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting	01380			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33163	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/25/2024
NAME OF PROVIDER OR SUPPLIER ULTIMATE CARE ASSISTED LIVING SPRING L			STREET ADDRESS, CITY, STATE, ZIP CODE 7931 6TH STREET NE SPRING LAKE PARK, MN 55432		
(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
01380	Continued From page 40 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 evaluations for the required topics were completed by one of one unlicensed personnel (ULP-C) prior to providing direct cares. 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 on March 21, 2023, to perform direct care services to the licensee's residents. On April 24, 2024, at 12:15 p.m., the surveyor observed ULP-C administer medications to R1 via gastrostomy tube.	01380			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33163	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/25/2024
NAME OF PROVIDER OR SUPPLIER ULTIMATE CARE ASSISTED LIVING SPRING L			STREET ADDRESS, CITY, STATE, ZIP CODE 7931 6TH STREET NE SPRING LAKE PARK, MN 55432		
(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	
01380	Continued From page 41 ULP-C's record lacked evidence of training prior to providing services for the following: - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; and - other RN delegated tasks(catheter care, stoma care, broad chair, mechanical lifts). On April 24, 2024, at 3:35 p.m. Licensed assisted living director (LALD)-A agreed that ULP-C's employee record was missing some of the required training and competency topics. LALD-A stated a different nurse that was no longer employed by the licensee completed the training and competency and they did not realize some topics were missing. The licensee's Staff Competency policy dated February 17, 2022, indicated home health aides may not work for the licensee until they have successfully past the written and demonstration competency evaluation including satisfactory completion of the following: - Observation, reporting and documenting of resident status; - Basic knowledge of body functioning and changes in body function, injuries or other reportable changes; - Recognizing physical, emotional, cognitive and development needs of the resident; - Basic infection control, including blood-borne pathogens; - Maintenance of a clean and safe environment; - Falls prevention; - Safe transfer techniques and ambulation; - Range of motion and positioning; - Administering medications or treatments as required;	01380			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33163	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/25/2024
NAME OF PROVIDER OR SUPPLIER ULTIMATE CARE ASSISTED LIVING SPRING L			STREET ADDRESS, CITY, STATE, ZIP CODE 7931 6TH STREET NE SPRING LAKE PARK, MN 55432		
(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	
01380	Continued From page 42 - Basic nutrition, meal preparation, food safety and assistance with eating; - Preparation of modified diets; - Communication skills and barriers; - Cultural diversity; - Confidentiality/privacy; - Professional boundaries; - Handling of emergencies; and - Commonly used help technology equipment and assistive devices. The policy also indicated the following topics must be completed by a practical skills test: - Appropriate and safe techniques in personal hygiene and grooming, including bathing, hair care, oral hygiene (teeth, gums, and oral prosthetics), care and use of hearing aids, dressing and toileting; - Safe transfer techniques and ambulation; - Range of motion and positioning; - Reading and recording temperature, pulse and respirations; - Administration of medications and treatments, as required; and - Other delegated tasks. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380			
01470 SS=D	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;	01470			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33163	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/25/2024
NAME OF PROVIDER OR SUPPLIER ULTIMATE CARE ASSISTED LIVING SPRING L			STREET ADDRESS, CITY, STATE, ZIP CODE 7931 6TH STREET NE SPRING LAKE PARK, MN 55432		
(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	
01470	Continued From page 43 (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 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	01470			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33163	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/25/2024
NAME OF PROVIDER OR SUPPLIER ULTIMATE CARE ASSISTED LIVING SPRING L			STREET ADDRESS, CITY, STATE, ZIP CODE 7931 6TH STREET NE SPRING LAKE PARK, MN 55432		
(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
01470	Continued From page 44 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 observation, interview, and record review, the licensee failed to ensure employees received orientation to assisted living licensing requirements and regulations prior to providing services for one of two employees 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, 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 on March 21, 2023, to perform direct care services to the licensee's residents. On April 24, 2024, at 12:15 p.m., the surveyor observed ULP-C administer medications to R1 via gastrostomy tube. ULP-C's employee record lacked documented evidence of the following: - Overview of Assisted Living statutes;	01470			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33163	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/25/2024
NAME OF PROVIDER OR SUPPLIER ULTIMATE CARE ASSISTED LIVING SPRING L			STREET ADDRESS, CITY, STATE, ZIP CODE 7931 6TH STREET NE SPRING LAKE PARK, MN 55432		
(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
01470	Continued From page 45 - Review of provider's policies and procedures; - Handling of resident complaints; - Consumer advocacy services; - Review of types of Assisted Living services the employee will provide and provider's scope of license; - Principals of person-centered planning/service delivery. On April 24, 2024, at 3:20 p.m., clinical nurse supervisor (CNS)-A stated the licensed assisted living director (LALD)-A assigned all the orientation classes for staff. On April 24, 2024, at 3:35 p.m., LALD-A stated he had assigned the incorrect classes to ULP-C for their orientation, and this is why they were missing the required orientation topics. The licensee's Staff Orientation and Education policy dated February 17, 2022, indicated orientation topics will include, but not be limited to, the following: -Overview of Minnesota assisted living statute 144G and Minnesota rules chapter 4659; -Review of the employees job description and responsibilities; -Introduction to and review of the organizations 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 Minnesota's Vulnerable Adult, including requirements based on organizational policy, identification of incidents and maltreatment and any act that constitutes maltreatment is prohibited; -The Assisted Living Bill of Rights and the employees responsibilities to ensure the exercise	01470			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33163	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/25/2024
NAME OF PROVIDER OR SUPPLIER ULTIMATE CARE ASSISTED LIVING SPRING L			STREET ADDRESS, CITY, STATE, ZIP CODE 7931 6TH STREET NE SPRING LAKE PARK, MN 55432		
(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	
01470	Continued From page 46 and protection of those rights; -The principles of person-centered planning and service delivery and how they apply to direct support services provided by staff; -Grievance policy/process, including reports to the office of health facility complaints; -Consumer advocacy services; -The types of assisted living services the employee will be providing based on the uniform checklist disclosure of services in the organizations category of licensure; and -The organizational chart enrolls a staff within the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470			
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such	01500			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33163	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/25/2024
NAME OF PROVIDER OR SUPPLIER ULTIMATE CARE ASSISTED LIVING SPRING L			STREET ADDRESS, CITY, STATE, ZIP CODE 7931 6TH STREET NE SPRING LAKE PARK, MN 55432		
(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	
01500	Continued From page 47 as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by:	01500			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33163	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/25/2024
NAME OF PROVIDER OR SUPPLIER ULTIMATE CARE ASSISTED LIVING SPRING L			STREET ADDRESS, CITY, STATE, ZIP CODE 7931 6TH STREET NE SPRING LAKE PARK, MN 55432		
(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
01500	Continued From page 48 Based on observation, interview, and record review, the licensee failed to ensure employees received at least eight (8) hours of annual training for each 12 months of employment in the required topics for one of one employee 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 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 on March 21, 2023, to perform direct care services to the licensee's residents. On April 24, 2024, at 12:15 p.m., the surveyor observed ULP-C administer medications to R1 via gastrostomy tube. ULP-C's record lacked evidence annual training had been completed as required in the following areas: - Reporting maltreatment of vulnerable adults or minors; - Assisted Living Bill of Rights; - Infection control techniques; - Effective approaches to use to problems 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 provider's policies and procedures; and - Principles of person-centered planning/service	01500			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33163	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/25/2024
NAME OF PROVIDER OR SUPPLIER ULTIMATE CARE ASSISTED LIVING SPRING L			STREET ADDRESS, CITY, STATE, ZIP CODE 7931 6TH STREET NE SPRING LAKE PARK, MN 55432		
(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	
01500	Continued From page 49 delivery. On April 24, 2024, at 3:35 p.m., licensed assisted living director (LALD)-A stated ULP-C's record did not contain any annual training in the required topics because he had forgot to assign it when it was due in March. The licensee's Staff Orientation and Education policy dated February 17, 2022, indicated all staff providing assisted living services will complete at least 8 hours of education for every 12 months of employment. Education topics will include, but not be limited to, the following: -Reporting of maltreatment of adults -Review the Assisted Living Bill of Rights -Review of the organization's policies and procedures -Infection control techniques -Effective approaches to use to problem solve when working with residents challenging behaviors and how to communicate with residents who have dementia; and -The principles of person-centered planning and service delivery. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500			
01530 SS=F	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	01530			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33163	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/25/2024
NAME OF PROVIDER OR SUPPLIER ULTIMATE CARE ASSISTED LIVING SPRING L			STREET ADDRESS, CITY, STATE, ZIP CODE 7931 6TH STREET NE SPRING LAKE PARK, MN 55432		
(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
01530	Continued From page 50 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 by: Based on observation, interview, and record review, the licensee failed to ensure supervisors of direct-care staff received at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date for one of two employees (clinical nurse supervisor (CNS)-B). In addition, the licensee failed to ensure direct-care staff completed at least two hours of annual dementia care training for each twelve months of employment for one of one (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, but was not likely to	01530			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33163	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/25/2024
NAME OF PROVIDER OR SUPPLIER ULTIMATE CARE ASSISTED LIVING SPRING L			STREET ADDRESS, CITY, STATE, ZIP CODE 7931 6TH STREET NE SPRING LAKE PARK, MN 55432		
(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	
01530	Continued From page 51 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: CNS-B CNS-B was hired on January 11, 2024, to provide supervision and oversight to unlicensed personnel and to provide direct services to residents. On April 23, 2024, at 10:00 a.m., the surveyor observed CNS-B working for the licensee and gathering paperwork the surveyor requested. CNS-B's employee record indicated CNS-B completed 2.25 hours of initial dementia training, thus did not contain documentation CNS-B completed the required initial eight hours of dementia training, within 120 working hours of CNS-B's employment start date under the assisted living license. On April 24, 2024, at 3:20 p.m., CNS-B stated she thought she had completed more dementia training but is not sure why it is not showing on her education transcript. ULP-C ULP-C was hired on March 21, 2023, to perform direct care services to the licensee's residents. On April 24, 2024, at 12:15 p.m., the surveyor observed ULP-C administer medications to R1 via gastrostomy tube. ULP-B's employee record indicated ULP-C completed 0 hours of annual dementia care	01530			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33163	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/25/2024
NAME OF PROVIDER OR SUPPLIER ULTIMATE CARE ASSISTED LIVING SPRING L			STREET ADDRESS, CITY, STATE, ZIP CODE 7931 6TH STREET NE SPRING LAKE PARK, MN 55432		
(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
01530	Continued From page 52 training, thus did not contain documentation ULP-C completed the required two hours of annual dementia care training for each twelve months of employment under the assisted living license. On April 24, 2024, at 3:35 p.m., licensed assisted living director (LALD)-A stated CNS-B was missing the required eight hours of initial dementia care training and ULP-C's record did not contain any annual dementia training because he had forgotten to assign the classes to the employees. The licensee's Dementia Education policy dated February 17, 2022, indicated supervisors of direct-care staff we'll have at least 8 hours of initial education within 120 working hours of employment start date in the following topics: -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. Direct care employees will complete at least two hours of education on topics related to dementia for each 12 months 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 (c) Resident reassessment and monitoring must	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33163	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/25/2024
NAME OF PROVIDER OR SUPPLIER ULTIMATE CARE ASSISTED LIVING SPRING L			STREET ADDRESS, CITY, STATE, ZIP CODE 7931 6TH STREET NE SPRING LAKE PARK, MN 55432		
(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
01620	Continued From page 53 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 (RN) completed ongoing reassessment and monitoring on or before days 14 and 90 and failed to use the uniform assessment tool for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33163	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/25/2024
NAME OF PROVIDER OR SUPPLIER ULTIMATE CARE ASSISTED LIVING SPRING L			STREET ADDRESS, CITY, STATE, ZIP CODE 7931 6TH STREET NE SPRING LAKE PARK, MN 55432		
(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
01620	Continued From page 54 the residents). The findings include: On April 22, 2024, at 1:30 p.m., licensed assisted living director (LALD)-A stated the nurse completed assessments on admission, 14 day, 90 days, and with change in condition. R1 was admitted and began receiving services on November 30, 2023. R1's record included an initial assessment dated November 30, 2023, a 14-day assessment which was undated and unsigned, and a 90-day assessment dated March 11, 2024, which was eleven days after the assessment was due. The assessments did not include all the required elements on the uniform assessment tool. On April 24, 2024, at 3:20 p.m., clinical nurse supervisor (CNS)-B stated they use the same forms and electronic format for all initial, 14-day, and 90-day assessments and stated they do not meet the requirements of the uniform assessment tool. The licensee's Comprehensive Nursing Assessment policy dated February 17, 2022, indicated the registered nurse (RN) will conduct a comprehensive assessment for all residents admitted to [the facility] to determine the services required and to develop an individualized care plan for staff to implement. The RN will conduct a comprehensive assessment utilizing a uniform assessment tool. The RN will provide a reassessment visit to update the evaluation of the resident and services no more than 14 days after initiation of services. Ongoing resident reassessments must be conducted by an RN and	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33163	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/25/2024
NAME OF PROVIDER OR SUPPLIER ULTIMATE CARE ASSISTED LIVING SPRING L			STREET ADDRESS, CITY, STATE, ZIP CODE 7931 6TH STREET NE SPRING LAKE PARK, MN 55432		
(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	
01620	Continued From page 55 cannot exceed 90 days from the last assessment. The Minnesota Administrative Rule 4659.0150 dated August 11, 1021, indicated each facility must develop a uniform assessment tool to include all the required elements. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620			
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency	01650			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33163	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/25/2024
NAME OF PROVIDER OR SUPPLIER ULTIMATE CARE ASSISTED LIVING SPRING L			STREET ADDRESS, CITY, STATE, ZIP CODE 7931 6TH STREET NE SPRING LAKE PARK, MN 55432		
(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
01650	Continued From page 56 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 resident service plans included all the required content for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: R1 was admitted to and began receiving services on November 30, 2023. R1's service plan dated November 30, 2023, lacked the following: -a description of the services to be provided 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 service -the schedule and methods of monitoring assessments of the resident -the schedule and methods of monitoring staff providing services	01650			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33163	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/25/2024
NAME OF PROVIDER OR SUPPLIER ULTIMATE CARE ASSISTED LIVING SPRING L			STREET ADDRESS, CITY, STATE, ZIP CODE 7931 6TH STREET NE SPRING LAKE PARK, MN 55432		
(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
01650	Continued From page 57 On April 24, 2024, at 2:50 p.m., licensed assisted living director (LALD)-A stated he sent the surveyor all the service plan information the day before and all requirements should be met. The licensee's Service Plan policy dated February 17, 2022, indicated the service plan includes the following: -a description of the services to be provided; the service description may be in the form of the resident's care plan developed with the resident/responsible party -the fees for services and the frequency of each service, according to the resident's current review or assessment and resident preferences -the identification of the staff or categories of staff who will provide the services -the schedule and methods of monitoring reviews or assessments of the resident -the schedule and method of monitoring staff providing services No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650			
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following:	01730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33163	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/25/2024
NAME OF PROVIDER OR SUPPLIER ULTIMATE CARE ASSISTED LIVING SPRING L		STREET ADDRESS, CITY, STATE, ZIP CODE 7931 6TH STREET NE SPRING LAKE PARK, MN 55432			
(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
01730	Continued From page 58 (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and maintain a current individualized medication management record to include all required content for one of one resident (R1).	01730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33163	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/25/2024
NAME OF PROVIDER OR SUPPLIER ULTIMATE CARE ASSISTED LIVING SPRING L			STREET ADDRESS, CITY, STATE, ZIP CODE 7931 6TH STREET NE SPRING LAKE PARK, MN 55432		
(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
01730	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, 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 24, 2024, at 12:15 p.m., the surveyor observed unlicensed personnel (ULP)-C administer medications to R1 via gastrostomy tube. R1's record included a medication assessment dated November 30, 2023. Medication management services were not included on R1's service plan. The medication management plan lacked the following: -a statement describing the medication management services that will be provided -identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis -identification of medication management tasks that may be delegated to unlicensed personnel - procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services Any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complication or adverse reactions.	01730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33163	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/25/2024
NAME OF PROVIDER OR SUPPLIER ULTIMATE CARE ASSISTED LIVING SPRING L			STREET ADDRESS, CITY, STATE, ZIP CODE 7931 6TH STREET NE SPRING LAKE PARK, MN 55432		
(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
01730	Continued From page 60 On April 24, 2024, clinical nurse supervisor (CNS)-B stated the medication plan had missing requirements and does not know why. CNS-B further stated the same forms and electronic format are used for all residents. The licensee's Service Plan for Medication Management policy dated February 17, 2022, indicated [the facility] will prepare and document a medication management plan as part of the service plan for each resident receiving medication management services. The written medication management plan includes the following provisions: -a statement describing the medication management services to be provided -identification of person (s) responsible for monitoring medication supplies and ensuring refills are ordered/timely -description of medication management tasks to be delegated to unlicensed personnel -plans for staff notifying the licensed health professional when/if a problem with medication management services arises -any resident-specific requirements related to documenting medication administration, verification that all medications are administered as prescribed and monitoring of medication use to prevent possible complications or adverse reactions No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730			
01770 SS=F	144G.71 Subd. 9 Documentation of medication setup	01770			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33163	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/25/2024
NAME OF PROVIDER OR SUPPLIER ULTIMATE CARE ASSISTED LIVING SPRING L		STREET ADDRESS, CITY, STATE, ZIP CODE 7931 6TH STREET NE SPRING LAKE PARK, MN 55432			
(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
01770	Continued From page 61 Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure documentation of medication setup included all the required content for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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). The findings include: R2's record lacked medication set-up documentation to include name of medication, quantity of doses, times to be administered, and routes of administration. On April 24, 2024, at 9:00 a.m. the surveyor observed clinical nurse supervisor (CNS)-B set up medications in a medication bar for R2. CNS-B stated for documentation of medication set-ups she writes a note in the resident's electronic record indicating "medications have been set up for the week". CNS-B further stated she was not aware of the documentation requirements for medication set-ups.	01770			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33163	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/25/2024
NAME OF PROVIDER OR SUPPLIER ULTIMATE CARE ASSISTED LIVING SPRING L			STREET ADDRESS, CITY, STATE, ZIP CODE 7931 6TH STREET NE SPRING LAKE PARK, MN 55432		
(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
01770	Continued From page 62 The licensee's Medication Documentation policy dated February 17, 2022, indicated [the facility] will document medication set up according to the following: a. Date of medication set up b. Name of medication c. Quantity of dose d. Times to be administered e. Route of administration f. Name/title of person completing medication set up No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770			
01880 SS=D	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure prescription medications were stored according to the manufacturer's directions for one of one resident (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	01880			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33163	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/25/2024
NAME OF PROVIDER OR SUPPLIER ULTIMATE CARE ASSISTED LIVING SPRING L			STREET ADDRESS, CITY, STATE, ZIP CODE 7931 6TH STREET NE SPRING LAKE PARK, MN 55432		
(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	
01880	Continued From page 63 was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On April 22, 2024, at 2:00 p.m., the surveyor observed the assisted living medication refrigerator with licensed assisted living director (LALD)-A which contained six unopened Basaglar insulin pens for R3. The manufacturer's guidelines for Basaglar insulin pens dated November 2023, recommended to store unused pens in the refrigerator at 36°F to 46°F. On April 23, 2024, at 2:30 p.m., the surveyor received four identical temperature logs for January, February, March, and April 2024. All four logs had the dates listed as one through thirty-one and every box on the sheet was filled in. The log identified a kitchen fridge, freezer, and medication fridge with boxes to write in both an AM and PM temperature reading, all boxes were filled in with various temperature readings from 33°F to 46°F. On April 23, 2024, at 2:30 p.m., LALD-A stated the temperature logs provided were not accurate because all four months were identical and appeared to be copies with a different month listed on the top of the log. LALD-A agreed the staff were not logging the medication refrigerator temperature as they were trained to. The licensee's Storage/Control of Medications policy dated February 17, 2022, indicated when licensee is providing storage of medications	01880			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33163	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/25/2024
NAME OF PROVIDER OR SUPPLIER ULTIMATE CARE ASSISTED LIVING SPRING LAKE			STREET ADDRESS, CITY, STATE, ZIP CODE 7931 6TH STREET NE SPRING LAKE PARK, MN 55432		
(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
01880	Continued From page 64 outside of the resident's private living space, all prescription drugs are securely locked in substantially constructed compartments according to the manufacturer's directions. Medications requiring refrigeration are clearly labeled and stored in an enclosed container or area separated from foods. Temperature is maintained at 35-40 degrees. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880			
01940 SS=F	144G.72 Subd. 3 Individualized treatment or therapy management For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to	01940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33163	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/25/2024
NAME OF PROVIDER OR SUPPLIER ULTIMATE CARE ASSISTED LIVING SPRING L			STREET ADDRESS, CITY, STATE, ZIP CODE 7931 6TH STREET NE SPRING LAKE PARK, MN 55432		
(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
01940	Continued From page 65 documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: R1 had diagnoses to include muscle weakness and diabetes. On April 23, 2024, at 12:04 p.m., the surveyor observed unlicensed personnel (ULP)-C feed R1 via the feeding tube. R1's medication and treatment administration record indicated R1 received blood glucose monitoring once daily, dressing changes to the g-tube site, and water flushes to the g-tube.	01940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33163	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/25/2024
NAME OF PROVIDER OR SUPPLIER ULTIMATE CARE ASSISTED LIVING SPRING L			STREET ADDRESS, CITY, STATE, ZIP CODE 7931 6TH STREET NE SPRING LAKE PARK, MN 55432		
(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	
01940	Continued From page 66 R1's record failed to include procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services. R1's service plan dated November 30, 2023, did not include any treatments. On April 23, 2024, at 12:15 p.m., clinical nurse supervisor (CNS)-B stated there were no parameters written down for staff for when to notify a nurse regarding high or low blood glucose readings. They just call the nurse if the reading is higher or lower than his normal. On April 24, 2024, at 2:50 p.m., CNS-B stated she did not know why the treatment and therapy plans were missing some of the required content and would have to ask licensed assisted living director (LALD)-A. The licensee's Treatment and Therapy Management policy dated February 17, 2022, indicated the RN or licensed health professional will prepare an individualized treatment or therapy management plan for each resident receiving ordered or prescribed treatments or therapy services, which addresses: Type of service to be provided Procedures for documenting treatments or therapies Procedures for monitoring treatments or therapies to prevent possible complications or adverse reactions. Identification of treatment or therapy tasks delegated to unlicensed personnel Procedures for notifying the RN or licensed health professional when a problem arises related to the treatment or therapy service.	01940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33163	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/25/2024
NAME OF PROVIDER OR SUPPLIER ULTIMATE CARE ASSISTED LIVING SPRING L			STREET ADDRESS, CITY, STATE, ZIP CODE 7931 6TH STREET NE SPRING LAKE PARK, MN 55432		
(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
01940	Continued From page 67 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940			
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the care and services were provided according to acceptable health care and medical, or nursing standards for three of three residents (R1, R2, R3) with an assistive device (hospital side rail), which resulted in an immediate correction order. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 On April 23, 2024, at 11:00 a.m., the surveyor	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33163	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/25/2024
NAME OF PROVIDER OR SUPPLIER ULTIMATE CARE ASSISTED LIVING SPRING L			STREET ADDRESS, CITY, STATE, ZIP CODE 7931 6TH STREET NE SPRING LAKE PARK, MN 55432		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
02310	Continued From page 68 observed a bilateral (two sides) side rails on R1's hospital bed. The bedrails were rectangular and measured approximately 32 inches long and 18 inches high, the mid-section had vertical bars spaced at approximately two and a half to three and a half inches apart. R1's diagnoses included muscle weakness and diabetes. R1's undated Side Rail Use Assessment Form, indicated R1 was non-ambulatory, had a history of falls, difficulty with balance, poor trunk control, and medications which may require safety precautions. The assessment indicated R1 used the side rail to assist with positioning. R1's record lacked: - documentation of risks versus benefits - measurements were completed and documented. On April 23, 2024, at 2:15 p.m., clinical nurse supervisor (CNS)-B stated they do not have documentation of risks versus benefits for the use of side rails and they do not have measurements of the side rails. CNS-B further stated the same bed rail assessment form is used for all residents with bed rails. The Food and Drug Administration (FDA) guidelines titled Recommendations for Health Care Providers about Bed Rails, dated July 9, 2018, indicated health care providers should base the use of bed rails on individual resident assessments to ensure the individual is an appropriate candidate to reduce the risk of entrapment. Recommendations made for health care providers to evaluate the individual's need,	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33163	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/25/2024
NAME OF PROVIDER OR SUPPLIER ULTIMATE CARE ASSISTED LIVING SPRING L			STREET ADDRESS, CITY, STATE, ZIP CODE 7931 6TH STREET NE SPRING LAKE PARK, MN 55432		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
02310	Continued From page 69 to use the guidance documented "Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment" to have knowledge that not all bed rails, mattresses, and bed frames are interchangeable; check the manufacturer's instructions, health care providers are to avoid the routine use of adult bed rails without first conducting an individual patient or resident assessment, and restrict the use of physical restraints including restrictive use of bed rails, or chest, abdominal, wrist, or ankle restraints of any kind on individuals in bed. When installing and using bedrails, select the appropriate bed rail, follow the health care provider's procedures, or manufacturer's recommendations, inspect, evaluate, and regularly check bedrails are appropriately matched to equipment and patient needs considering all relevant risk factors, to identify and remove potential fall and entrapment hazards. Be aware that gaps can be created by movement or compression of the mattress, which may be caused by patient weight, movement, bed position, or by using a specialty mattress. The FDA identifies vulnerable patients as those "who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement or who get out of bed and walk unsafely without assistance." These patients most often have been frail, elderly, or confused. FDA guidelines titled Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment, dated 2006, identified key body parts at risk for life-threatening entrapment of the head, neck, and chest in the seven zones of a hospital bed system, focusing on the most common zones for risk of entrapment - zones 1-4. - Zone 1 - within the rail is any open space with the perimeter of the rail. Recommended space be less than 4 ¾ inches representing head breadth.	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33163	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/25/2024
NAME OF PROVIDER OR SUPPLIER ULTIMATE CARE ASSISTED LIVING SPRING L			STREET ADDRESS, CITY, STATE, ZIP CODE 7931 6TH STREET NE SPRING LAKE PARK, MN 55432		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
02310	Continued From page 70 - Zone 2 - under the rail, between the rail supports or next to a single rail support. This space is the gap under the rail between a mattress compressed by the weight of a patient's head and the bottom edge of the rail at the location between the rail supports or next to a single rail support. Recommended space limit for entrapment in this space is less than 4 ¾ inches. - Zone 3 - between the rail and the mattress. The space between the inside surface of the rail and the mattress compressed by the weight of a patient's head. The space should be small enough to prevent head entrapment. Recommended space between the area between the inside surface of the rail and compressed mattress should be of less than 4 ¾ inches. - Zone 4 - under the rail at the ends of the rail. This space poses a risk for entrapment of a patient's neck. In this space, a gap forms between the mattress compressed by the patient, and the lowermost portion of the rail, at the end of the rail. Recommended dimension for this zone measure both less than 60 mm in size and greater than 60 degrees in angle. The licensee's Side Rail Use policy effective date February 17, 2022, indicated before implementing side rails for a resident, the RN will conduct a side rail assessment. The RN will discuss with the resident/representative (s) alternatives to the use of side rails. The RN will document the purpose of the side rails and the education provided. The resident, resident's legal representative or resident's designated representative will co-sign the document agreeing to the benefits and risks of the side rails. The need for side rails will be reassessed and documented as needed, but not less than every 90 days.	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33163	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/25/2024
NAME OF PROVIDER OR SUPPLIER ULTIMATE CARE ASSISTED LIVING SPRING L			STREET ADDRESS, CITY, STATE, ZIP CODE 7931 6TH STREET NE SPRING LAKE PARK, MN 55432		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
02310	Continued From page 71 The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) dated June 21, 2023, indicated, "Licensees should review the CSPC website regularly for updates on recalled portable bed rails. The opportune time to do this would be with the 90-day assessment due to the requirement included in the uniform assessment tool for assessing assistive devices and documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks) - The resident's preferences - Installation and use according to manufacturer's guidelines - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements." No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	02310			



Minnesota Department of Health

625 Robert Street North
St Paul
651-201-4500

Type: Full
Date: 04/23/24
Time: 11:38:29
Report: 7994241084

Food and Beverage Establishment Inspection Report

Page 1

Location:

Ultimate Care Assisted Living-
7931 6th Street Ne
Spring Lake Park, MN55432
Anoka County, 02

Establishment Info:

ID #: 0038520
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7635609890
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.

6-300 Physical Facility Numbers and Capacities

6-301.11

**** Priority 2 ****

MN Rule 4626.1440 Provide an adequate supply of hand soap at each handwashing sink or group of 2 adjacent handwashing sinks.

BOTTLE OF DISH SOAP CURRENTLY BEING USED AS HAND SOAP. PROVIDE AN APPROVED SOAP DISPENSER.

Comply By: 04/23/24

2-100 Supervision

2-102.12AMN

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

NO CURRENT CFPM. A STAFF MEMBER RECENTLY COMPLETED AN APPROVED COURSE. CFPM WEBSITE LINK INCLUDED IN EMAIL.

Comply By: 04/23/24

4-500 Equipment Maintenance and Operation

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

DISHWASHER RECENTLY BROKE DOWN. FACILITY IS WORKING ON REPLACING OR REPAIRING THE DISHWASHER.

Comply By: 04/23/24

Type: Full
Date: 04/23/24
Time: 11:38:29
Report: 7994241084
Ultimate Care Assisted Living-

Food and Beverage Establishment Inspection Report

6-300 Physical Facility Numbers and Capacities
6-301.14A

MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands
THERE IS A TWO BASIN SINK IN THE KITCHEN AREA. DESIGNATE ONE BASIN AS THE HANDWASH SINK AND PROVIDE A SIGN DETAILED ABOVE.
Comply By: 04/23/24

Total Orders	In This Report	Priority 1	Priority 2	Priority 3
		0	1	3
INSPECTION CONDUCTED IN THE PRESENCE OF HRD STAFF AND FINDINGS SHARED AT THE END OF INSPECTION.				
WILL EMAIL SUPPORTING DOCUMENTS AND LINKS TO HRD STAFF AT THE END OF THE DAY.				
KITCHEN IS RESIDENTIAL AND FOOD IS PREPARED FOR SAME DAY SERVICE				

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 7994241084 of 04/23/24.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: ____/____/____

Signed:_____
Establishment Representative

Signed: 
Crystal Elva
Public Health Sanitarian 3
St Paul
651-201-3981
Crystal.Elva@state.mn.us

Report #: 7994241084		Food Establishment Inspection Report									
m DEPARTMENT OF HEALTH Minnesota Department of Health 625 Robert Street North St Paul		No. of RF/PHI Categories Out		2		Date 04/23/24					
		No. of Repeat RF/PHI Categories Out		0		Time In 11:38:29					
		Legal Authority MN Rules Chapter 4626				Time Out					
Ultimate Care Assisted Living-		Address 7931 6th Street Ne		City/State Spring Lake Park, MN		Zip Code 55432		Telephone 7635609890			
License/Permit # 0038520		Permit Holder		Purpose of Inspection Full		Est Type		Risk Category			
FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS											
Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item											
Mark "X" in appropriate box for COS and/or R											
IN= in compliance OUT= not in compliance N/O= not observed N/A= not applicable COS=corrected on-site during inspection R= repeat violation											
Compliance Status				COS		R					
Supervision											
1	IN	OUT	PIC knowledgeable; duties & oversight								
2	IN	OUT	N/A	Certified food protection manager, duties							
Employee Health											
3	IN	OUT	Mgmt/Staff;knowledge,responsibilities&reporting								
4	IN	OUT	Proper use of reporting, restriction & exclusion								
5	IN	OUT	Procedures for responding to vomiting & diarrheal events								
Good Hygienic Practices											
6	IN	OUT	N/O	Proper eating, tasting, drinking, or tobacco use							
7	IN	OUT	N/O	No discharge from eyes, nose, & mouth							
Preventing Contamination by Hands											
8	IN	OUT	N/O	Hands clean & properly washed							
9	IN	OUT	N/A	N/O	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed						
10	IN	OUT		Adequate handwashing sinks supplied/accessible							
Approved Source											
11	IN	OUT		Food obtained from approved source							
12	IN	OUT	N/A	N/O	Food received at proper temperature						
13	IN	OUT		Food in good condition, safe, & unadulterated							
14	IN	OUT	N/A	N/O	Required records available; shellstock tags, parasite destruction						
Protection from Contamination											
15	IN	OUT	N/A	N/O	Food separated and protected						
16	IN	OUT	N/A		Food contact surfaces: cleaned & sanitized						
17	IN	OUT		Proper disposition of returned, previously served, reconditioned, & unsafe food							
GOOD RETAIL PRACTICES											
Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.											
Mark "X" in box if numbered item is not in compliance Mark "X" in appropriate box for COS and/or R COS=corrected on-site during inspection R= repeat violation											
				COS		R					
Safe Food and Water											
30	IN	OUT	N/A	Pasteurized eggs used where required							
31				Water & ice obtained from an approved source							
32	IN	OUT	N/A	Variance obtained for specialized processing methods							
Food Temperature Control											
33				Proper cooling methods used; adequate equipment for temperature control							
34	IN	OUT	N/A	N/O	Plant food properly cooked for hot holding						
35	IN	OUT	N/A	N/O	Approved thawing methods used						
36				Thermometers provided & accurate							
Food Identification											
37				Food properly labeled; original container							
Prevention of Food Contamination											
38				Insects, rodents, & animals not present							
39				Contamination prevented during food prep, storage & display							
40				Personal cleanliness							
41				Wiping cloths: properly used & stored							
42				Washing fruits & vegetables							
Food Recalls:											
Person in Charge (Signature)											
Date: 04/23/24											
Inspector (Signature)											