Electronically Delivered

October 30, 2024

Licensee
Solace Health Services LLC
9317 Minnesota Lane North
Maple Grove, MN 55369

RE: Project Number(s) SL37707015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on October 3, 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.

MDH 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.

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

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

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

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the

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

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

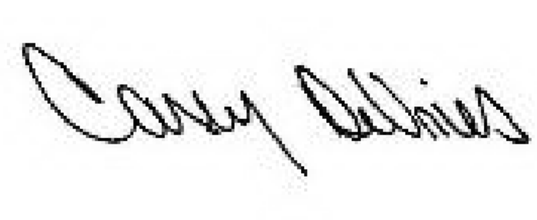
To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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

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

If you have any questions, please contact me.

Sincerely,



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

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37707	A. BUILDING: _____ B. WING _____	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOLACE HEALTH SERVICES LLC	9317 MINNESOTA LANE NORTH MAPLE GROVE, MN 55369

(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 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: SL37707015-0 On September 30, 2024, through October 3, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were two resident(s); both of whom were receiving services under the Assisted Living Facility license.	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.	
0 460 SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request	0 460		

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0 460	Continued From page 1 assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide a means for residents to request assistance for health and safety needs 24 hours a day, seven days a week. 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 September 30, 2024, at 9:52 a.m., during the	0 460		

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0 460	Continued From page 2 entrance conference, licensed assisted living director (LALD)-C, acknowledged not having a call system for the residents and stated, "No, because all of our residents are up and about, but if we were to get someone in a wheelchair or bed bound then we would for sure need to get one." When asked if LALD-C was aware of the statute requirements, LALD-C stated, "Yes, I am aware, the reason why is because we have only had one [resident] and so we have been 1:1 [staff to resident ratio] but right now we have two." On September 30, 2024, at 10:45 a.m., during a facility tour, the surveyor observed a three-level home with two resident rooms located in the basement, one resident room located on the main floor, and two resident rooms located on the upper floor. In addition, there was a third room on the upper floor being utilized as a conference room. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 460		
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,	0 660		

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0 660	Continued From page 3 contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to 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 three employees (unlicensed personnel (ULP)-B, ULP-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-B ULP-B was hired on May 19, 2021, to provide direct care services to residents. On September 30, 2024, at 12:58 p.m., the surveyor observed ULP-B administer medication to R3.	0 660		

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0 660	Continued From page 4 ULP-B's employee records contained a Consent & Release for TB Screening form, dated September 1, 2024, and lacked evidence of screening for active TB with either a two-step TST or blood test within 90 days of hire. ULP-F ULP-F was hired on November 8, 2021, to provide direct care services to residents. ULP-F's employee records contained a radiology report dated November 10, 2020, and lacked evidence of screening for active TB with either a two-step TST or blood test within 90 days of hire. On October 1, 2024, at 1:33 p.m., licensed assisted living director (LALD)-C stated, "For the TB for [ULP's] that was an oversite, I don't have it." The licensee's 8.16 Tuberculosis Screening policy, dated August 1, 2021, read, "Staff whose essential job functions require work within the same airspace of home care clients [residents] will be screened and tested for tuberculosis prior to the staff being exposed to the clients. Baseline (upon hire) screening will be completed but serial (annual) screening will only be required with increased occupational risk or exposure." The CDC Tuberculosis Screening, Testing, and Treatment of U.S. Health Care Personnel dated May 17, 2019, indicated all health personnel should have a baseline screening and an individual risk assessment, which is necessary for interpreting any test result. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 660		

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0 660	Continued From page 5 (21) days	0 660		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the portable fire extinguishers. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 October 4, 2024, at approximately 11:00 a.m., on a facility tour with licensed assisted living	0 790		

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0 790	Continued From page 6 director (LALD)-C, the surveyor observed the following: - The portable fire extinguishers throughout the facility where not installed on their required wall mount brackets. - Monthly inspections had not been recorded on the back of the tags attached to the portable fire extinguishers. Fire extinguisher inspections must be conducted every month to ensure that each extinguisher is in its designated place, that it has not been tampered with, and that there is no obvious physical damage or condition that would interfere with its use or operation. On October 4, 2024, at approximately 12:30 p.m. survey staff explained to LALD-C that the portable fire extinguishers must be mounted and inspected to ensure all portable extinguishers are readily available, fully charged, and operable at their designated location. LALD-C stated they understood the requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program.	0 800		

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0 800	Continued From page 7 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation regarding the health, safety, comfort, and well-being of the residents. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On October 4, 2024, at approximately 11:00 a.m., on a facility tour with licensed assisted living director LALD-C. The following was observed. GENERAL MAINTENANCE: The stone veneer on the exterior of the building was missing. Several pieces were observed on the ground below. The soffit and facia on the front of the facility was missing, and unsecured. This allows animals and weather to access the interior of the home. The handrail to the upper level was loose and unstable.	0 800		

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0 800	Continued From page 8 The electrical junction box above the furnace in the lower-level mechanical room was missing the cover. The drywall at the base of the mechanical room had significant black staining and warping of the wall from exposure to moisture. Water staining was observed on the ceiling of the activity room. The ceiling in the hallway outside the lower-level mechanical room was missing. Caulking around the tub in the upper-level hallway bathroom was missing. On October 8, 2024, at 12:30 p.m., LALD-C stated they understood the above-listed deficiencies. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar	0 810		

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0 810	Continued From page 9 emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the 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).	0 810		

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0 810	Continued From page 10 The findings include: On October 4, 2024, survey staff observed the fire evacuation diagrams did not include the identification of the path of egress and did not properly identify each sleeping room. Exit plan diagrams must be correctly labeled to reduce confusion and potential obstructions to egress in a fire or similar emergency. On October 4, 2024, at approximately 12:00 p.m. LALD-C provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP failed to include the following: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The provided FSEP was from a third-party provider and had not been updated to the specific facility. The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar	0 810		

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0 810	Continued From page 11 emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation nor did it include instructions for staff to follow in case of relocation. On October 4, 2024, at 12:30 p.m., LALD-C stated they understood the areas of their policy that were incomplete and would work on bringing them into compliance. TRAINING: The licensee failed to provide evacuation training to residents at least once per year. LALD-C lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan. The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. On October 4, 2024, at 12:30 p.m., LALD-C stated they understood the requirements for training residents and staff and would implement a training program that was compliant with statute requirements. DRILLS: The licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. Record review of licensee's evacuation drill log indicated 2nd shift evacuation drills were not conducted. No other documentation was provided. On October 4, 2024, at 12:30 p.m., LALD-C	0 810		

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0 810	Continued From page 12 stated there were no additional documented drills for the facility. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal property for one of one resident reviewed (R3). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R3 was admitted to the licensee and began receiving assisted living services on May 31,	0 970		

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	37707	A. BUILDING: _____ B. WING _____	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOLACE HEALTH SERVICES LLC	9317 MINNESOTA LANE NORTH MAPLE GROVE, MN 55369

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0 970	Continued From page 13 2024. R3's record included a [Licensee] Assisted Living Contract signed by R3 on May 31, 2024, which read, "Miscellaneous Provisions: Insurance Liability and Release. The resident shall maintain at all times his or her own health, personal property, liability, automobile (if applicable), and other insurance coverages and shall provide evidence of same by copies of binders or policies provided to [licensee] upon request. The resident acknowledges that [licensee] is not an insurer of the resident's person or property. The resident agrees that [licensee] will not be liable to the resident for any personal injury or property damage (including without limitation, damage to, or loss or theft of, automobiles or personal property of resident) suffered by the resident or the resident's agents, guests or invitees, unless and to the extent that the injury or damage is caused by the negligence of [licensee] or its employees or agents. The resident hereby releases [licensee] from liability for any personal injury or property damage suffered by the resident or the resident's agents, guests, or invitees, unless caused by the negligence of [licensee] or its employees or agents." On September 30, 2024, at 12:08 p.m., licensed assisted living director (LALD)-C acknowledged that all the residents used the same contract and stated, "Yes, we use the same, they are all the same." On October 2, 2024, at 11:34 a.m., LALD-C stated, "I know that the wording is supposed to be different, but I did not look into the details, the newest contract is the same one so we will change it to say may not."	0 970		

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0 970	Continued From page 14 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01370 SS=F	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family;	01370		

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01370	Continued From page 15 (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 were completed for all required skill areas, prior to providing services, for two of three unlicensed personnel ((ULP)-B, ULP-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-B ULP-B was hired on May 19, 2021, to provide direct care services to residents. On September 30, 2024, at 12:58 p.m., the surveyor observed ULP-B administer medication to R3. ULP-B's record lacked evidence of training for the following required content:	01370		

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01370	Continued From page 16 -maintenance of a clean and safe environment; -training on the prevention of falls for providers working with the elderly or individuals at risk of falls; -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; -understanding appropriate boundaries between staff and residents and the resident's family; and -procedures to utilize in handling various emergency situations. ULP-F ULP-F was hired on November 8, 2021, to provide direct care services to residents. ULP-F's record lacked the following required content: -standby assistance techniques and how to perform them; -understanding appropriate boundaries between staff and residents and the resident's family; and -procedures to utilize in handling various emergency situations. On October 1, 2024, at 12:45 p.m., ULP-B stated "I did training with [clinical nurse supervisor (CNS)-D] at the Champlin House [another location owned by the same licensee]. It was over two years ago so I don't remember much. For competencies, [CNS-D] would explain how to do it, I would demonstrate back, if there was anything I did wrong she would go over it with me until I got it right." On October 1, 2024, at 1:32 p.m., licensed assisted living director (LALD)-C stated, "I know we changed our forms as the old forms are missing some information, so for newer	01370		

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01370	Continued From page 17 employees our forms have everything, but I don't think I went back and fixed those hired before this year." On October 1, 2024, at 2:53 p.m., ULP-E stated, "We had very thorough training with [CNS-D] nobody can work until they have done their training so first we did orientation and [CNS-D] trained me on all that. Lots of forms to sign and then she would set me up with Educare [an electronic training system] so I would do all of the computer training and then we did our one on one where she did all of the training even on stuff that we don't use like how to use the call system, and she trained on how to do special movements and transferring, even though we don't have to do that. We had to learn how to do all the things that you have to do as a CNA [certified nursing assistant] and then we had to show her that we could do it. After we showed her that we could do it we were allowed to work on the floor and then she had to come back and make sure we were still doing it right. She also trained us on all the meds even meds that we don't give so I learned how to do an inhaler and eye drops and nose drops and how to crush meds and all the things that you can think of to do with meds, we had to learn them, even if we're not utilizing that skill right now, and then every year we have to go through training again." On October 2, 2024, at 11:34 a.m., CNS-D stated all competencies are completed one on one with the RN (registered nurse) before the staff member works on the floor. The licensee's 5.02 Competency Training Evaluations policy dated August 1, 2021, indicated the licensee would train on all of the above mentioned items, and a copy of all	01370		

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01370	Continued From page 18 education, training, and competency testing would be kept in each employee's personnel file. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01380 SS=F	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency evaluations were completed for all required skill areas, prior to providing services, for two of three unlicensed personnel ((ULP)-B, ULP-F). This practice resulted in a level two violation (a	01380		

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01380	Continued From page 19 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-B was hired on May 19, 2021, to provide direct care services to residents. On September 30, 2024, at 12:58 p.m., the surveyor observed ULP-B administer medication to R3. ULP-B's record lacked evidence of training for the following required content: -observation, reporting, and documenting of resident status; -basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; -reading and recording temperature, pulse, and respirations of the resident; and -recognizing physical, emotional, cognitive, and developmental needs of the resident. ULP-F was hired on November 8, 2021, to provide direct care services to residents. ULP-F's record lacked evidence of training for the following required content: -range of motioning and positioning. On October 1, 2024, at 12:45 p.m., ULP-B stated "I did training with [clinical nurse supervisor (CNS)-D] at the Champlin House [another	01380		

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01380	Continued From page 20 location owned by the same licensee]. It was over two years ago so I don't remember much. For competencies, [CNS-D] would explain how to do it, I would demonstrate back, if there was anything I did wrong she would go over it with me until I got it right." On October 1, 2024, at 1:32 p.m., licensed assisted living director (LALD)-C stated, "I know we changed our forms as the old forms are missing some information, so for newer employees our forms have everything, but I don't think I went back and fixed those hired before this year." On October 1, 2024, at 2:53 p.m., ULP-E stated, "We had very thorough training with [CNS-D] nobody can work until they have done their training so first we did orientation and [CNS-D] trained me on all that. Lots of forms to sign and then she would set me up with Educare [an electronic training system] so I would do all of the computer training and then we did our one on one where she did all of the training even on stuff that we don't use like how to use the call system, and she trained on how to do special movements and transferring, even though we don't have to do that. We had to learn how to do all the things that you have to do as a CNA [certified nursing assistant] and then we had to show her that we could do it. After we showed her that we could do it we were allowed to work on the floor and then she had to come back and make sure we were still doing it right. She also trained us on all the meds even meds that we don't give so I learned how to do an inhaler and eye drops and nose drops and how to crush meds and all the things that you can think of to do with meds, we had to learn them, even if we're not utilizing that skill right now, and then every year we have to go	01380		

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01380	Continued From page 21 through training again." On October 2, 2024, at 11:34 a.m., CNS-D stated all competencies are completed one on one with the RN (registered nurse) before the staff member works on the floor. The licensee's 5.02 Competency Training Evaluations policy dated August 1, 2021, indicated the licensee would train on all of the above mentioned items, and a copy of all education, training, and competency testing would be kept in each employee's personnel file. No further information was 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; (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	01470		

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01470	Continued From page 22 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 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	01470		

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01470	Continued From page 23 review, the licensee failed to ensure one of three employees (unlicensed personnel (ULP)-B) completed an orientation to assisted living facility licensing requirements and regulations before providing services to 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-B was hired on May 19, 2021, to provide direct care services to residents. On September 30, 2024, at 12:58 p.m., the surveyor observed ULP-B administer medication to R3. ULP-B's employee record lacked documentation of orientation training in the following required areas: -overview of Assisted Living statutes; -handling of resident complaints, reporting of complaints, where to report; and -review of types of Assisted Living services the employee will provide and provider's scope of license; On October 1, 2024, at 12:45 p.m., ULP-B stated "I did training with [clinical nurse supervisor (CNS)-D] at the Champlin House [another location owned by the same licensee]. It was over two years ago so I don't remember much. For	01470		

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01470	Continued From page 24 competencies, [CNS-D] would explain how to do it, I would demonstrate back, if there was anything I did wrong she would go over it with me until I got it right." On October 2, 2024, at 11:34 a.m., CNS-D stated all trainings are completed one on one with the RN (registered nurse) before the staff member works on the floor. The licensee's 4.05 Employee Records policy dated August 1, 2021, indicated "[Licensee] will keep an employee record for all paid employees. Employee records will be kept up-to-date and confidential." In addition, the policy indicated "Records of all training and in-service education required and/or provided including record of competency testing is required." The policy did not address the specific required content. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01540 SS=E	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 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	01540		

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01540	Continued From page 25 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 direct-care staff completed at least eight hours of initial dementia care training within 80 working hours of the employment start date for two of three employees (unlicensed personnel (ULP)-B, ULP-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-B ULP-B was hired on May 19, 2021, to provide direct care services to residents. On September 30, 2024, at 12:58 p.m., the surveyor observed ULP-B administer medication to R3. ULP-B's Educare (an electronic training system)	01540		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01540	Continued From page 26 indicated six hours and 15 minutes of dementia training had been completed between May 26, 2023, through June 12, 2023. ULP-B's employee records lacked eight hours of initial dementia care training within 160 working hours of the employment start date. ULP-F ULP-F was hired on November 8, 2021, to provide direct care services to residents. ULP-F's employee file included knowledge assessments titled, Dementia Communication, Problem Solving- Overview, Dementia-Person-Centered Care, Dementia Activities of Daily Living, and Dementia Introduction and Overview; all dated November 18, 2021. The knowledge assessments failed to include the number of hours trained. ULP-F's employee records lacked evidence eight hours of initial dementia care training within 160 working hours of the employment start date were completed. On October 2, 2024, at 11:34 a.m., during an interview with clinical nurse supervisor (CNS)-D and licensed assisted living director (LALD)-C, CNS-D stated, "Dementia training is assigned on Educare, they are given two days to complete the eight hours of training." LALD-C stated, "They are supposed to complete it all but apparently some were missed. We will have to look into it." Licensee Training & Competencies Manual - 3.00a dated June 2021 indicated "Direct Care Staff 8 hours of initial training within 80 hours of your first day of employment that includes: -An explanation of Alzheimer's disease and other dementias, -Assistance with activities of daily living, -Problem solving with challenging behaviors, -Communication skills, and	01540		

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	37707	A. BUILDING: _____ B. WING _____	10/03/2024

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01540	Continued From page 27 -Person-centered planning and service delivery." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01540		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 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	01620		

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	37707	A. BUILDING: _____ B. WING _____	10/03/2024

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01620	Continued From page 28 (RN) conducted ongoing nursing assessments not to exceed every 90-days for two of two residents (R2, 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2 R2 was admitted to the licensee and began receiving assisted living services on November 2, 2021. R2's record included 90-day assessments dated March 16, 2024, June 13, 2024, and September 13, 2024, indicating 92 days had passed between the June 13, 2024, and September 13, 2024, assessments. R3 R3 was admitted to the licensee and began receiving assisted living services on May 31, 2024. R3's record included a 14-day assessment dated June 12, 2024, and a 90-day assessment dated September 13, 2024, indicating 93 days had passed between the assessments. On October 2, 2024, clinical nurse supervisor (CNS)-D stated, "We completed the assessment on time, but may not have completed the documentation on the same day." CNS-D	01620		

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01620	Continued From page 29 acknowledged that there was no way to indicate the assessment was done prior to the electronic time and date stamp on the assessment. The licensee's 6.01 Assessments, Reviews & Monitoring policy dated August 1, 2021, read, "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." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition.	01910		

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	37707	A. BUILDING: _____ B. WING _____	10/03/2024

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01910	Continued From page 30 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide documentation in the resident's record regarding the disposition of medication to include the medication strength, prescription number, quantity, date of disposition, and names of staff and other individuals involved in the disposition for one of three discharged residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 was discharged from the licensee to another assisted living facility on May 22, 2024. R1's record lacked a medication disposition to include the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. On September 30, 2024, at 1:11 p.m., licensed assisted living director (LALD)-C stated, "The list of medications at discharge is usually the last page and I know I gave that to [R1] I didn't keep a copy of it though and I don't know why I didn't keep a copy of it, because I know I was the one	01910		

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	37707	A. BUILDING: _____ B. WING _____	10/03/2024

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01910	Continued From page 31 to discharge her. So, I don't have her disposition of medications." The Licensee's 7.23 Medication Disposal policy, dated August 1, 2021, indicated, "Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure unlicensed personnel (ULP)-B followed appropriate medication administration procedures. 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	02320		

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02320	Continued From page 32 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-B was hired on May 19, 2021, to provide direct care services to residents. ULP-B's employee record included a competency sign off form on oral medication administration signed July 27, 2021. On September 30, 2024, at 12:58 p.m., the surveyor observed ULP-B preform hand hygiene, don gloves, and remov the container that was previously set up by the nurse containing R3's afternoon medications. Without verifying on the electronic medication administration record (EMAR), ULP-B dumped the contents of the pill container into a medication cup and administered the medication to R3. ULP-B then walked back to the medication cart, turned on the computer and opened RTasks (a documenting software program), marked verify and administered on buspirone 15 milligram tablet. On September 30, 2024, at 1:05 p.m., ULP-B stated, "Normally I would pull it up first and confirm that it was the one for today, but she (R3) was in a hurry to leave, and I didn't want her to leave before she took her medication." On October 2, 2024, clinical nurse supervisor (CNS)-D stated ULP's were trained to use the five rights of medication administration, and to count the number of pills because while the medications	02320		

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02320	Continued From page 33 were set up by the nurse, there could be the chance that there could be something missing. The licensee's 7.08 Medication Management - Administration & setup policy dated August 1, 2021, indicated "ULP will verify medications are set up correctly in the dosage box before administration to the resident by use of the medication profile." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		

Minnesota Department of Health

625 North Robert Street
Saint Paul, MN
651-201-5000

Type: Full
Date: *10/02/24*
Time: 14:00:00
Report: 8087241202

Food and Beverage Establishment Inspection Report

Location:

Solace Health Services Llc
9317 Minnesota Lane North
Maple Grove, MN55369
Hennepin County, 27

Establishment Info:

ID #: 0037555
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7634898422
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.

No NEW orders were issued during this inspection.

Food and Equipment Temperatures

Process/Item: Ambient Air
Temperature: 13 Degrees Fahrenheit - Location: SAMSUNG FREEZER
Violation Issued: No

Process/Item: Ambient Air
Temperature: 34 Degrees Fahrenheit - Location: SAMSUNG REFRIGERATOR
Violation Issued: No

Process/Item: Cold Holding - MILK
Temperature: 34 Degrees Fahrenheit - Location: SAMSUNG REFRIGERATOR
Violation Issued: No

Process/Item: Cold Holding - CHEESE
Temperature: 34 Degrees Fahrenheit - Location: SAMSUNG REFRIGERATOR
Violation Issued: No

Process/Item: Cold Holding - DELI MEAT
Temperature: 35 Degrees Fahrenheit - Location: SAMSUNG REFRIGERATOR
Violation Issued: No

Process/Item: Cold Holding - YOGURT
Temperature: 34 Degrees Fahrenheit - Location: SAMSUNG REFRIGERATOR
Violation Issued: No

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

THIS WAS AN ANNOUNCED AND SCHEDULED FULL INSPECTION.

INSPECTION CONDUCTED IN THE PRESENCE OF NURSE EVALUATOR TESA BROWN.

Food and Beverage Establishment Inspection Report

FLOORS AND CABINETS ARE HARDWOOD AND CEILING DOES NOT APPEAR TO BE DURABLE, SMOOTH IN TEXTURE AND EASILY CLEANABLE. ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT SUCH A TIME THEY ARE FOUND TO BE A CONCERN OR RISK OF CONTAMINATION, THEY WILL BE ORDERED TO BE REPLACED AND BROUGHT UP TO CODE.

SAMSUNG BRAND DISHWASHER IS RESIDENTIAL BUT HAS SANITIZING RINSE CYCLE OPTION. HIGH TEMO STRIPS AND TEMP LOG ON SITE.

DESIGNATED HAND WASHING SINK IN THE KITCHEN IS THE RIGHT SIDE OF A 2-BIN, STAINLESS STEEL, RESIDENTIAL KITCHEN SINK.

INSPECTION REPORT EMAILED TO NURSE EVALUATOR TESA BROWN.

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 8087241202 of 10/02/24.

Certified Food Protection Manager: GLADYS N. NYABWARI

Certification Number: FM112941 Expires: 09/12/25

Inspection report reviewed with person in charge and emailed.

Signed: _____

GLADYS N. NYABWARI
DIRECTOR

Signed: _____

John Boettcher
Public Health Sanitarian 3
St. Paul, MN / Freeman
651-201-5076
john.boettcher@state.mn.us