Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

July 22, 2024

Licensee
A-A-H Mercy Home Health LLC
3554 June Avenue North
Robbinsdale, MN 55422

RE: Project Number(s) SL33981015

Dear Licensee:

On July 8, 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 on April 11, 2024. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the April 11, 2024 survey.

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.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on April 11, 2024, found not corrected at the time of the July 8, 2024, follow-up survey and/or subject to penalty assessment are as follows:

0470 - Minimum Requirements-144g.41 Subdivision 1 - $500.00
0650 - Employee Records-144g.42 Subd. 8 - $500.00

The details of the violations noted at the time of this follow-up survey completed on July 8, 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 $1,000.00**. 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.

We urge you to review these orders carefully. If you have questions, please contact Jess Schoenecker at 651-201-3789.

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,

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

AH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33981	A. BUILDING: ____ B. WING ____	R 07/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A-A-H MERCY HOME HEALTH	**3554 JUNE AVENUE NORTH ROBBINSDALE, MN 55422**

(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: SL33981015-1 On July 8, 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 11, 2024. At the time of the survey, there were three (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.	
{0 470} SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	{0 470}		

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{0 470}	Continued From page 1 determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to evaluate the staffing plan at least twice a year, potentially affecting all the licensee's current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and	{0 470}		

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{0 470}	Continued From page 2	{0 470}		
	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:			
	On July 8, 2024, at approximately 1:30 p.m., licensed assisted living director (LALD)-F produced an undated Facility Staffing Plan and indicated it was the staffing plan for [licensee]. The staffing plan lacked documentation that it had been reviewed at least twice per year.			
	On July 8, 2024, at approximately 1:30 p.m., clinical nurse supervisor (CNS)-B stated the licensee was unaware of the requirement to review the staffing plan at least twice yearly.			
	The licensee's Staffing policy dated December 14, 2022, read "the staffing plan shall be evaluated as part of the Quality Management program at least twice per year. The results of the evaluation are documented in the meeting minutes."			
	No further information was provided.			
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	{0 480}		
	(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:			

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{0 480}	Continued From page 3 No further action required.	{0 480}		
{0 630} SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the 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 develop an individual abuse prevention plan (IAPP) with the required content for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: R2 was admitted on January 1, 2022, and began receiving assisted living services.	{0 630}		

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{0 630}	Continued From page 4	{0 630}		

Continued From page 4

R2's Service Plan dated July 1, 2022, indicated R2's services included medication administration and assistance with laundry.

R2's IAPP dated July 8, 2024, failed to include the following required information:
- the resident's susceptibility to abuse by another individual, including other vulnerable adults;
-the resident's risk of causing harm to other vulnerable adults; and
- statements of specific measures to be taken to minimize the risk of abuse by other individuals, including other vulnerable adults.

On July 8, 2024, at approximately 2:05 p.m., clinical nurse supervisor (CNS)-B stated the R-Task system (online medical record system) did not include the questions in the assessment portion of the program and the R-Task system would be updated to include the required information.

The licensee's Vulnerable Adult policy dated December 14, 2022, read "an individual abuse prevention plan shall be established for each vulnerable minor or adult for whom assisted living services are provided:
1) the plan shall contain an individual assessment of the resident's susceptibility to abuse by another individual, including other vulnerable adults;
2) the plan shall contain the resident's risk of abusing other vulnerable adults;
3) the plan shall contain statements of specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults;
4) the plan will be implemented immediately and evaluated at each supervisory visit or more frequently, if necessary; and
5) documentation will include results of the

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{0 630}	Continued From page 5 implementation." No further information was provided.	{0 630}		
{0 650} SS=F	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received orientation to include all required content for two of two employees (unlicensed personnel ((ULP)-C, ULP-D).	{0 650}		

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{0 650}	Continued From page 6 This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a 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 the potential to affect a large portion or all of the residents). The findings include: ULP-C ULP-C was hired on May 12, 2023, and began providing assisted living services. ULP-C's employee record lacked documentation of the following required orientation topics: -overview of assisted living statutes; -assisted living bill of rights and staff responsibilities to ensuring the exercise and protection of those rights; -orientation to provider's policies and procedures; -consumer advocacy services; -principles of person-centered planning/service delivery; and -review of the types of assisted living services the employee will be providing and the facility's category of licensure ULP-D ULP-D had a hire date of May 3, 2023, and began providing assisted living services. ULP-D's employee record lacked documentation of the following required orientation topics: -overview of assisted living statutes; -review of provider's policies and procedures; -reporting maltreatment of vulnerable adults or minors;	{0 650}		

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{0 650}	Continued From page 7 -handling of resident complaints, reporting of complaints, where to report; -consumer advocacy services; -review of types of assisted living services the employee will provide and provider's scope of license; and -principles of person-centered planning/service delivery. ULP-D's employee record also lacked training and competency documentation for all areas required under Minnesota Statute 144G.61 Subd. 2. On July 8, 2024, at approximately 2:15 p.m., clinical nurse supervisor (CNS)-B stated competency training had been completed for ULP-D and they were unsure where to locate the documents. On July 8, 2024, at approximately 2:15 p.m., licensed assisted living director (LALD)-F, director (D)-A, and CNS-B stated that ULP-C and ULP-D's employee records did not include all required orientation topics and LALD-F, D-A, and CNS-B stated they were unaware of topics required for orientation. The license's Staff Competency policy dated December 14, 2022, indicated the clinical nurse supervisor was responsible for the overall competency evaluation program and no one may provide direct care to residents on behalf of [licensee] before successfully passing the competency evaluation. The licensee's Staff Orientation and Education policy dated October 7, 2022, indicated orientation topics would include: -overview of Minnesota Assisted Living statute	{0 650}		

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{0 650}	Continued From page 8 144G and Minnesota Rules Chapter 4659; -review of the employee's job description and responsibilities; -introduction to and review of the organization's policies and procedures related to the provision of assisted living services by the individual staff person; -handling of emergencies and the use of emergency services; -compliance with Minnesota's Vulnerable Adult (Sections 626.556 and 5772), including requirements based on organizational policy, identification of incidents of maltreatment (abuse, financial exploitation, and neglect) and that any act that constitutes maltreatment is prohibited; -the assisted living bill of rights and the employee's responsibilities to ensure the exercise and protection of those rights; -the principles of person-centered planning and service delivery and how they apply to direct support services provided by 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 and the organization's category of licensure; and -the organizational chart and roles of staff within the facility. The licensee's Staff Orientation and Education policy dated October 7, 2022, also indicated upon hire, those employees providing direct care services will complete a competency evaluation as part of the orientation process. No further information was provided.	{0 650}		

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{01820}	Continued From page 9	{01820}		
{01820} SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to ensure there was a current, written, or electronically recorded prescription for all prescribed medications that the assisted living facility was managing for one of two residents (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) 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 incident has occurred only occasionally). The findings include: R2 was admitted on January 1, 2022, and began receiving assisted living services. R2's Service Plan dated July 1, 2022, indicated R2 received medication administration and assistance with laundry. R2's unsigned and undated Individualized Medication Management Plan indicated R2 received medication administration by the licensee's staff.	{01820}		

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{01820}	Continued From page 10 R2's record contained a Medication and Treatment orders form signed by the physician on April 2, 2024. The medications noted on the form were crossed out and a note with 'see attached". The Medication and Treatment orders form lacked additional attached documents. R2's record contained an After Visit summary (AVS) report dated April 2, 2024, which included a medication list. The AVS lacked an electronic signature from an authorized prescriber. R2's record lacked evidence of a current, written or electronically recorded prescription for all medications the facility was managing for R2. On July 8, 2024, at approximately 2:00 p.m., clinical nurse supervisor (CNS)-stated the prescriber orders had not been updated by the physician and they thought another staff member had sent the orders to the physician's office for authentication. The licensee's Prescriber's Orders policy dated December 14, 2022, indicated written orders from an authorized prescriber will be obtained for all medications and treatments with which the assisted living facility assists residents, including over the counter medications. No further information was provided.	{01820}		

Electronically Delivered
May 9, 2024

Licensee
A-A-H Mercy Home Health
3554 June Avenue North
Robbinsdale, MN 55422

RE: Project Number(s) SL33981015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 11, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

The correction order documentation should include the following:

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

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In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued,

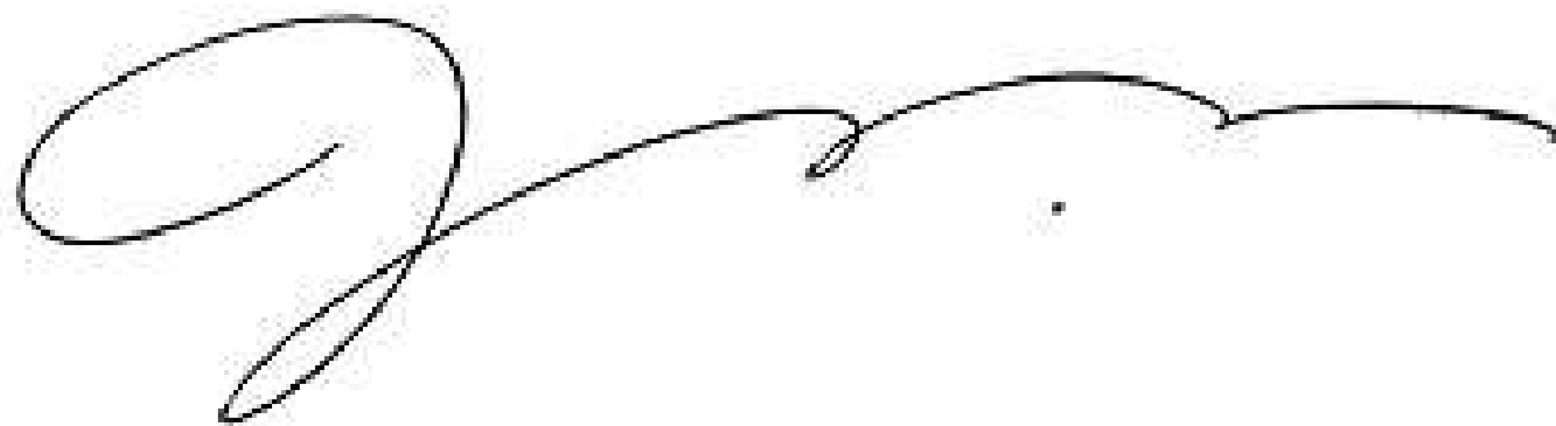
including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by MDH within 15 calendar days of the correction order receipt date.

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.

Sincerely,



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

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33981	A. BUILDING: ____ B. WING ____	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A-A-H MERCY HOME HEALTH	3554 JUNE AVENUE NORTH ROBBINSDALE, MN 55422

(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: SL33981015-0 On April 8, 2024, through April 11, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 3 residents; 2 receiving services under the Assisted Living 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 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.	
0 430 SS=A	144G.40 Subd. 2 Uniform checklist disclosure of services (a) All assisted living facilities must provide to	0 430		

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0 430	Continued From page 1	0 430		

prospective residents:
(1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility;
(2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and
(3) an oral explanation of the services offered under the contract.
(b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract.
(c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a).

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to provide licensee's Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) to one of one resident (R2).

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 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:

R2 admitted on January 1, 2022, and began receiving assisted living services.

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0 430	Continued From page 2 R2's record contained an unsigned, undated UDALSA. R2's record lacked documentation R2 received licensee's UDALSA. On April 11, 2024, at approximately 10:37 a.m., assisted living director in residence (ALDIR)-E stated they were unaware that documentation of R2 having received the licensee's UDALSA was missing from the record. ALDIR-E stated the form would be completed and added to R2's record. The licensee's Notifications policy dated December 14, 2022, read "[licensee] will obtain written acknowledgement of the resident's receipt of the assisted living bill of rights, notice of privacy and UDALSA from the resident or the resident's representative or document why an acknowledgement could not be obtained." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 430		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies	0 470		

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0 470	Continued From page 3	0 470		

and to emergency, life safety, and disaster situations affecting staff or residents in the facility;
(12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be:
(i) awake;
(ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time;
(iii) capable of communicating with residents;
(iv) capable of providing or summoning the appropriate assistance; and
(v) capable of following directions;

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to evaluate the staffing plan at least twice a year, potentially affecting all the licensee's current residents, staff, and visitors.

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

On April 8, 2024, at approximately 1:10 p.m., director (D)-A produced an undated staffing plan and indicated it was the staffing plan for the facility. The plan indicated there would be 2 staff

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0 470	Continued From page 4 members working each shift in the facility. The staffing plan also lacked documentation that it had been reviewed at least twice per year. On April 9, 2024, at 1:30 p.m., D-A stated the plan did not reflect actual staffing of the facility and would be updated. D-A stated the licensee was unaware of the requirement to review the staffing plan at least twice yearly. The licensee's Staffing policy dated December 14, 2022, read "the staffing plan shall be evaluated as part of the Quality Management program at least twice per year. The results of the evaluation are documented in the meeting minutes." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a	0 480		

Minnesota Department of Health

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0 480	Continued From page 5 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 8, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by:	0 580		

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0 580	Continued From page 6	0 580		

Based on interview and record review, the licensee failed to implement and maintain a quality management program (QMP) appropriate to the size of the facility and relevant to the type of services provided. This had the potential to affect all current residents, staff, and visitors.

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

The findings include:

On April 8, 2024, at approximately 11:00 a.m., when asked about quality management activities during the entrance conference, director (D)-A stated the licensee held staff meetings and discussed cleaning, food, and customer service.

On April 9, 2024, at 1: 15 p.m., D-A provided a quality improvement policy and stated they thought they had additional quality management documents but were unable to locate them.

The licensee's Quality Improvement policy dated December 14, 2022, read "[licensee] has established a quality improvement program based on the organization's size and appropriate to the type of services provided in order to assure that effective, comprehensive, and appropriate plans are operational for all residents within the organization."

No further information was provided.

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0 580	Continued From page 7 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 580		
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the 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 develop an individual abuse prevention plan (IAPP) with the required content for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: R2 was admitted on January 1, 2022, and began	0 630		

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0 630	Continued From page 8	0 630		

receiving assisted living services.

R2's assessment dated April 2, 2024, indicated R2 was not at risk to be abused.

R2's IAPP dated July 1, 2022, indicated R2 was at risk for aggressive behaviors towards others and failed to include:
- the resident's susceptibility to abuse by another individual, including other vulnerable adults; and
- statements of specific measures to be taken to minimize the risk of abuse by other individuals, including other vulnerable adults.

On April 11, 2024, at 10:44 a.m., assisted living director in residence (ALDIR)-E stated the licensee was unaware the information in the IAPP and the assessment was incomplete. ALDIR-E stated their R-Task system (electronic charting system) would be updated to include required information.

The licensee's Vulnerable Adult policy dated December 14, 2022, read "an individual abuse prevention plan shall be established for each vulnerable minor or adult for whom assisted living services are provided:
1) the plan shall contain an individual assessment of the resident's susceptibility to abuse by another individual, including other vulnerable adults;
2) the plan shall contain the resident's risk of abusing other vulnerable adults;
3) the plan shall contain statements of specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults;
4) the plan will be implemented immediately and evaluated at each supervisory visit or more frequently, if necessary: and
5) documentation will include results of the implementation."

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0 630 Continued From page 9 0 630

No further information was provided.

TIME PERIOD FOR CORRECTION: Seven (7) days

0 650 SS=F 144G.42 Subd. 8 Employee records 0 650

(a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information:
(1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules;
(2) records of orientation, required annual training and infection control training, and competency evaluations;
(3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision;
(4) documentation of annual performance reviews that identify areas of improvement needed and training needs;
(5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and
(6) documentation of the background study as required under section 144.057.

This MN Requirement is not met as evidenced by:
Based on observation, interview, and record review, the licensee failed to ensure employees received orientation to include all required content for two of two employees (unlicensed personnel

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0 650	Continued From page 10	0 650		

((ULP)-C, ULP-D). Additionally, the licensee failed to ensure documented competencies were completed for one of two unlicensed personnel (ULP-D).

This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a 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 the potential to affect a large portion or all of the residents).

The findings include:

ULP-C
ULP-C was hired on May 12, 2023, and began providing assisted living services.

ULP-C's employee record lacked documentation of the following orientation topics required by Minnesota Statute 144G.63 Subdivision 2:
-orientation to provider's policies and procedures;
-consumer advocacy services;
-principles of person-centered planning/service delivery; and
-orientation to each specific resident and services provided.

ULP-D
ULP-D had a hire date of May 3, 2023, and began providing assisted living services.

On April 11, 2024, at 9:15 a.m., ULP-D was observed to administer oral medications to R2.

On April 11, 2024, at 9:20 a.m., ULP-D stated they were trained by clinical nurse supervisor

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(CNS)-F.

ULP-D's record lacked evidence documented competencies, including medication administration competencies.

ULP-D's employee record also lacked documentation of the following orientation topics required by Minnesota Statute 144G.63. Subdivision 2:
-overview of assisted living statutes;
-review of provider's policies and procedures;
-reporting maltreatment of vulnerable adults or minors;
-handling of resident complaints, reporting of complaints, where to report;
-consumer advocacy services;
-review of types of assisted living services the employee will provide and provider's scope of license;
-principles of person-centered planning/service delivery; and
-orientation to each specific resident and services provided.

On April 11, 2024, at approximately 10:00 a.m., director (D)-A stated competency training had been completed by CNS-F, but they were unsure why it had not been filed in employee record.

On April 11, 2024, at approximately 11:00 a.m., assisted living director in residence (ALDIR)-E stated they used an orientation checklist and were unsure why the orientation documentation was not in employee records.

CNS-F was not available for interview throughout the survey.

The license's Staff Competency policy dated

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0 650	Continued From page 12 December 14, 2022, indicated the clinical nurse supervisor was responsible for the overall competency evaluation program and no one may provide direct care to residents on behalf of [licensee] before successfully passing the competency evaluation. The licensee's Staff Orientation and Education policy dated October 7, 2022, indicated orientation topics would include: -overview of Minnesota Assisted Living statute 144G and Minnesota Rules Chapter 4659; -review of the employee's job description and responsibilities; -introduction to and review of the organization's policies and procedures related to the provision of assisted living services by the individual staff person; -handling of emergencies and the use of emergency services; -compliance with Minnesota's Vulnerable Adult (Sections 626.556 and 5772), including requirements based on organizational policy, identification of incidents of maltreatment (abuse, financial exploitation, and neglect) and that any act that constitutes maltreatment is prohibited; -the assisted living bill of rights and the employee's responsibilities to ensure the exercise and protection of those rights; -the principles of person-centered planning and service delivery and how they apply to direct support services provided by 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 and the organization's category of licensure; and -the organizational chart and roles of staff within	0 650		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 650	Continued From page 13 the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
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 the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included baseline testing and screening for one of two employees (unlicensed personnel (ULP)-D) and education for two of two employees (ULP-C, ULP-D).	0 660		

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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:

The licensee's Facility TB Risk Assessment form dated April 2, 2024, indicated the facility was at a low level of TB risk.

ULP-C
ULP-C was hired on May 12, 2023, and began providing assisted living services.

ULP-C's employee record lacked documentation of TB education on hire.

ULP-D
ULP-D was hired on May 3, 2023, and began providing assisted living services.

ULP-D's employee record contained a negative QuantiFERON TB Gold Plus (a blood test for TB) result dated May 23, 2023.

ULP-D's employee record lacked a TB history and symptom screen and TB education upon hire.

On April 11, 2024, at 11:00 a.m., assisted living director in residence (ALDIR)-E stated they were unaware of the missing information in ULP-D's employee record. ALDIR-E also stated they will assign TB education for all employees through their EDUCARE system (a software program

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0 660	Continued From page 15 offering online education). Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, indicated baseline TB screening consists of three components: 1. Assessing for current symptoms of active TB disease. 2. Assessing TB history; and 3. Testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step TST (given one to three weeks apart) or single Interferon-Gamma Release Assay (IGRA), a blood test that aids in diagnosing a tuberculosis infection. The regulations also indicated TB training was required at the time of hire for all healthcare workers. The licensee's Tuberculosis Screening/Prevention policy dated December 14, 2022, indicated [licensee] will observe the recommended precautions related to TB prevention as identified by the CDH and the Minnesota Department of Health (MDH). The precautions include the following elements: -risk assessment; -TB screening; and -staff education. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 720 SS=F	144G.43 Subd. 2 Access to records The facility must ensure that the appropriate records are readily available to employees and	0 720		

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0 720	Continued From page 16	0 720		

contractors authorized to access the records. Resident records must be maintained in a manner that allows for timely access, printing, or transmission of the records. The records must be made readily available to the commissioner upon request.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to ensure that the appropriate records for two of two residents (R1, R2) were readily available for timely access to employees, vendors, and the commissioner authorized to access the records.

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

The findings include:

On April 8, 2024, at approximately 11:15 a.m., during the entrance conference, clinical nurse supervisor (CNS)-B stated that medical records were stored both on paper and electronically. CNS-B stated the facility was transitioning from Adaptive Healthcare (an electronic medical record system) to R-Task (an electronic medical record system).

On April 8, 2024, at 2:12 p.m., surveyor sent licensee an email requesting records for R1 and R2. The record request included the most recent three assessments for R1 and R2.

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0 720	Continued From page 17 On April 9, 2024, at approximately 11:00 a.m., surveyor asked clinical nurse supervisor (CNS)-B to locate the most recent three assessments for R1 and R2. On April 9. 2024, at 11:40 a.m., CNS-B provided the surveyor with an assessment for R2 dated April 9, 2024. CNS-B stated the assessment was completed on April 2, 2024, and was retrieved from their R-Task system. CNS-B stated the other assessments that were requested could not be provided as they were unable to retrieve them from their electronic medical record system. The licensee's Clinical Records policy dated December 14, 2022, read "clinical records will be maintained in such a manner that allows for timely access, printing, or transmission of the records". No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 720		
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,	0 810		

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0 810	Continued From page 18 evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on the interview and record review, the licensee failed to develop the fire safety and evacuation plan with the required content, failed to provide the required training, and failed to provide the required 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, 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	0 810		

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0 810	Continued From page 19 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On April 9, 2024, at 10:00 a.m., house manager (D)-A and registered nurse (RN)-B provided documentation on the fire safety and evacuation plan (FSEP), fire safety and evacuation training for the facility, and fire safety and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The FSEP and the posted evacuation plans did not show the number of resident rooms and did not identify the required elements for fire safety and evacuation. The FSEP included standard employee actions to be taken but failed to provide specific procedures for employees to evacuate residents based on the facility's specific layout in the event 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 emergency including individualized unique needs of residents. The plan failed to include ways to move, evacuate residents based on the facility's specific layout in the event of a fire or similar emergency. During the interview on April 9, 2024, at 10:00 a.m., D-A stated the policy was from a third-party provider and had yet to be edited or updated to fit the facility-specific fire safety protocols. D-A also stated he was planning to rely on the Umatul Islam Center as an emergency relocation site;	0 810		

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0 810	Continued From page 20 however, he did not have any pre-arranged agreement with the facility. TRAINING Record review of the available documentation indicated employees did not receive training twice per year after initial hire. A policy or record were requested on employee training, and one was not provided. During the interview on April 9, 2024, at 10:00 a.m., D-A stated the licensee provided annual training on the fire safety and evacuation plan to employees via. EduCare program, but not twice per year after the initial hire, as required by statute. DRILLS Record review of the available documentation indicated that the licensee did not conduct evacuation drills twice per year per shift and every other month as required by statute. Records of the evacuation drills were requested, but one was not provided. During the interview on April 9, 2024, at 10:00 a.m., D-A stated the facility provided drills on 3/14/24, 1/12/24, and 11/16/23, and those drills were conducted at 9 a.m. and 3 p.m. for the morning shift only. D-A confirmed the facility did not conduct drills for the afternoon and night shift and failed to provide drills every other month as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		

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0 820	Continued From page 21	0 820		
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 ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide a resident bedroom with the minimum window opening meeting the minimum state standard for egress. This affected the occupied resident in bedroom #1 on the main level. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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:	0 820		

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0 820	Continued From page 22 On April 8, 2024, at 12:00 p.m., survey staff toured the facility with the house manager (D)-A. During the facility tour, survey staff observed the following items: It was observed unoccupied resident bedroom #1 on the main level did not have windows that met the minimum size requirements for egress escape. The clear openable area of the opened windows measured 38 inches in height and 18 inches in width, with a total openable area of 684 square inches. The windows did not meet the minimum requirements for opening width. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. During the interview on April 8, 2024, at 12:30 p.m., survey staff explained to D-A that at least one egress window in each bedroom must be provided to meet the minimum state standard for an egress window to be a complying bedroom for resident occupancy. D-A verbally confirmed the findings. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 820		
01060 SS=D	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent	01060		

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01060	Continued From page 23 risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and	01060		

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01060	Continued From page 24 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with required content for an emergency relocation and failed to notify the Office of Ombudsman for Long-Term Care of the emergency relocation 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted to licensee on February 3, 2023, and began receiving assisted living services. R1's service plan dated February 3, 2023, indicated R1's services included medication administration, dressing and grooming reminders, and food preparation. R1's Progress Notes dated February 20, 2024, indicated R1 was transferred to the hospital. R1's record lacked evidence of a written notice provided to the resident, the residents' legal representative, and designated representative that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident had been relocated	01060		

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and any new service provider;
- contact information for the Office of Ombudsman for Long-Term Care (OOLTC);
- if known and applicable, the approximate date or range of dates within which the resident was expected to return to the facility, or a statement that a return date was not currently known; and
- a statement that, if the facility refused to provide housing or services after a relocation, the resident had the right to appeal and the contact information for the agency to which the resident may submit an appeal.

R1's record also lacked documentation of Office of Ombudsman for Long-Term Care notification that R1 had not returned to the facility within four days.

On April 11, 2024, at 12:00 p.m., director (D)-A stated R1 was still in hospital, and they were not sure if he would be returning to the facility.

On April 11, 2024, at approximately 12:20 p.m., registered nurse (RN)-B stated that emergency relocation form and Ombudsman notification had not been completed as he was not working that day. RN-B stated that it should have been completed by clinical nurse supervisor (CNS)-F.

The licensee's Discharge and Transfer of Residents policy dated December 14, 2022, read "in the event of an emergency relocation, the facility will, as soon as possible, provide written notice of emergency relocation to the following:
-the resident;
-the resident's legal representative;
-the resident's designated representative;
-If the resident receives home and community-based services, the resident's case manager;

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01060	Continued From page 26 -if the resident has been relocated and not returned to [licensee] within four (4) days, the Office of Ombudsman for Long-Term Care; and -notice of the right to appeal the decision under 144G.54." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01060		
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced	01440		

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01440	Continued From page 27	01440		

by:
Based on interview and record review, the licensee failed to ensure documentation of direct supervision within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated task 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) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of employees are involved, or the situation has occurred only occasionally).

The findings include:

ULP-C was hired on May 12, 2023, and began providing assisted living services.

ULP-C's employee record contained Medication Administration Competency Evaluation dated May 12, 2023, and was authenticated by clinical nurse supervisor (CNS)-F.

ULP-C's employee record contained an unsigned Home Health Aide Supervision: Medication Management form dated January 14, 2024, which was not authenticated by a registered nurse. ULP-C's supervision of delegated task exceeded the 30-day requirements and was not authenticated by a registered nurse.

On April 11, 2024, at 11:00 a.m., registered nurse (RN)-B stated he wasn't working at the licensee's facility when ULP-C was hired and did not know why the supervision was not completed within the

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	33981	A. BUILDING: ______ B. WING ______	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A-A-H MERCY HOME HEALTH	**3554 JUNE AVENUE NORTH ROBBINSDALE, MN 55422**

(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
01440	Continued From page 28 required timeframe. The licensee's Supervision: Unlicensed Staff policy dated December 14, 2022, indicated direct supervision of home health aides performing delegated tasks will be provided within 30 days after the individual begins working for the assisted living provider and thereafter as needed based on performance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days	01440		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of	01640		

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01640	Continued From page 29	01640		

the current written service plan.

This MN Requirement is not met as evidenced by:
Based on observation, interview, and record review, the licensee failed to finalize a current written service plan within fourteen (14) calendar days 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 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:

R2 was admitted January 1, 2022, and began receiving assisted living services.

R2's record contained a signed service plan dated July 1, 2022, which exceeded the requirement of finalizing the service plan within 14 calendar days of the date the services are first provided. R2's record lacked a Service Plan dated within fourteen (14) days of admission.

On April 9, 2024, at approximately 12:30 p.m., registered nurse (RN)-B acknowledged R2's record lacked a service plan prior to July 1, 2022.

On April 11, 2024, at approximately 11:00 a.m., assisted living director in residence (ALDIR)-E stated they were unsure why the service plan was not completed within the required time frame. ALDIR-E stated they would print an updated

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01640	Continued From page 30 service plan based off R2's recent assessment and would place it in his record. The licensee's Service Plan policy dated December 14, 2022, read "the service plan will be finalized no later than 14 days after the date home care services are first provided, if not already completed." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01640		
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure there was a current, written, or electronically recorded prescription for all prescribed medications that the assisted living facility was managing for one of two residents (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) 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 incident has occurred only occasionally).	01820		

Minnesota Department of Health

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	33981	A. BUILDING: ________ B. WING ________	04/11/2024

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01820	Continued From page 31 The findings include: R2 was admitted on January 1, 2022, and began receiving assisted living services. R2's service plan dated July 1, 2022, indicated R2 received medication administration. R2's unsigned and undated Individualized Medication Management Plan indicated R2 received medication administration by facility staff. On April 11, 2024, at 9:00 a.m., unlicensed personnel (ULP)-D was observed administering oral medication to R2. R2's medication administration record (MAR) dated April 2024, indicated the following medications had been administered between April 1, 2024, and April 11, 2024: -cholecalciferol (vitamin D supplement); -lorazepam (restlessness); -olanzapine (antipsychotic); and -propranolol (restlessness). R2's record contained a Medication and Treatment orders form signed by the physician on April 2, 2024. The medications noted on the form were crossed out and a note with 'see attached". The Medication and Treatment orders form lacked additional attached documents. R2's record lacked evidence of a current, written or electronically recorded prescription for all medications the facility was managing for R1. R2's record contained an After Visit summary (AVS) report dated April 2, 2024, which included a medication list. The AVS lacked an electronic	01820		

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01820	Continued From page 32 signature from an authorized prescriber. On April 11, 2024, at 12:58 p.m., registered nurse (RN)-B stated the licensee considers the AVS reports received at physician appointments as their current medication orders. The licensee's Prescriber's Orders policy dated December 14, 2022, indicated written orders from an authorized prescriber will be obtained for all medications and treatments with which the assisted living facility assists residents, including over the counter medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
02240 SS=C	144G.90 Subdivision 1 Assisted living bill of rights; notification (a) An assisted living facility must provide the resident a written notice of the rights under section 144G.91 before the initiation of services to that resident. The facility shall make all reasonable efforts to provide notice of the rights to the resident in a language the resident can understand. (b) In addition to the text of the assisted living bill of rights in section 144G.91, the notice shall also contain the following statement describing how to file a complaint or report suspected abuse: "If you want to report suspected abuse, neglect, or financial exploitation, you may contact the Minnesota Adult Abuse Reporting Center (MAARC). If you have a complaint about the facility or person providing your services, you may contact the Office of Health Facility Complaints,	02240		

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02240	Continued From page 33 Minnesota Department of Health. If you would like to request advocacy services, you may contact the Office of Ombudsman for Long-Term Care or the Office of Ombudsman for Mental Health and Developmental Disabilities." (c) The statement must include contact information for the Minnesota Adult Abuse Reporting Center and the telephone number, website address, email address, mailing address, and street address of the Office of Health Facility Complaints at the Minnesota Department of Health, the Office of Ombudsman for Long-Term Care, and the Office of Ombudsman for Mental Health and Developmental Disabilities. The statement must include the facility's name, address, email, telephone number, and name or title of the person at the facility to whom problems or complaints may be directed. It must also include a statement that the facility will not retaliate because of a complaint. (d) A facility must obtain written acknowledgment from the resident of the resident's receipt of the assisted living bill of rights or shall document why an acknowledgment cannot be obtained. Acknowledgment of receipt shall be retained in the resident's record. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a copy of the assisted living bill of rights will all required elements for two of two residents (R1, R2). 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	02240		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33981	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED 04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02240	Continued From page 34 or has potential to affect a large portion or all the residents). The findings include: R1 R1 was admitted on February 3, 2023, and began receiving assisted living services. R1's service plan form dated February 3, 2023, identified services provided included medication administration, food preparation, housekeeping, laundry, and transportation services. R1's record contained an undated copy of 144G.91 Assisted Living Bill of Rights statues authenticated by the resident. The document lacked required content including: -the statement containing required language describing how to file a complaint or report suspected abuse; -contact information for the Minnesota Adult Abuse Reporting Center (MAARC); -the website address, email address, mailing address, and street address of the Office of Health Facility Complaints (OHFC) at the Minnesota Department of Health (MDH); and -the telephone number, website address, email address, mailing address, and street address of the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. R2 R2 was admitted on January 1, 2022, and began receiving assisted living services. R2's service plan form dated July 1, 2022, identified services provided to R2 included medication administration and assistance with	02240		

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02240	Continued From page 35	02240		

laundry services.

R2's record contained an undated copy of 144G.91 Assisted Living Bill of Rights statues authenticated by the resident. The document lacked required content including:
-the statement containing required language describing how to file a complaint or report suspected abuse;
-contact information for the MAARC;
-the website address, email address, mailing address, and street address of the OHFC at MDH; and
-the telephone number, website address, email address, mailing address, and street address of the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities.

On April 11, 2024, at approximately 11:00 a.m., assisted living director in residence (ALDIR)-E acknowledged that only the statutes had been provided to residents and stated they needed to update files with the bill of rights document containing all required elements.

The licensee's Notifications policy dated December 14, 2022, read "the resident or resident's representative will be provided with names and contact information, including telephone numbers and email addresses of at least three (3) organizations that provide advocacy or legal services to residents, including the designated protection and advocacy organization in Minnesota that provides advice and representation to individuals with disabilities. Included are how to file a complaint with:
-The OHFC at MDH;
-the Office of the Ombudsman for Long-Term Care;

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02240	Continued From page 36 -the Office of Ombudsman for Mental Health and Developmental Disabilities; and -the Mid-Minnesota Legal Aid/Minnesota Disability Law Center." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02240		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the required notice was posted at the main entry way of the facility to display statutory language to disclose electronic monitoring activity, potentially affecting all current residents in the assisted living facility, staff, and any visitors of the licensee. This practice resulted in a level one violation (a violation that has not potential to cause more than a minimal impact on the client 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 clients).	03090		

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03090	Continued From page 37 The finding include: On April 8, 2024, at 10:00 a.m., upon arrival to the licensee's facility, the surveyor did not observe a posting for electronic monitoring devices at the entrance to the facility. On April 11, 2024, at 11:00 a.m., assisted living director in residence (ALDIR)-E stated one of the residents did not like the posting and would remove it each time it was replaced. ALDIR-E stated they would continue to replace the sign. The licensee's Electronic Monitoring policy dated December 14, 2022, read "[licensee] will post a sign at each facility entrance accessible to visitors that states "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090		

Type:	Full
Date:	*04/08/24*
Time:	12:44:44
Report:	1036241066

Food and Beverage Establishment Inspection Report

Location:
A-A-H Mercy Home Health
3554 June Avenue North
Robbinsdale, MN55422
Hennepin County, 27

Establishment Info:
ID #: 0037576
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9522019645
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.

NO SOAP WAS AVAILABLE AT KITCHEN HANDWASHING SINK. ISSUE CORRECTED ON SITE.
Comply By: 04/08/24

2-100 Supervision

2-102.12AMN

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

NO CURRENT CFPM AT ESTABLISHMENT. COMPLY WITH ABOVE RULE.
Comply By: 04/29/24

Surface and Equipment Sanitizers

UTENSIL SURFACE TEMP: = at 160 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Hold/MILK
Temperature: 40 Degrees Fahrenheit - Location: KITCHEN FRIDGE
Violation Issued: No

Food and Beverage Establishment Inspection Report

Process/Item: Ambient Temp
Temperature: 5 Degrees Fahrenheit - Location: KITCHEN FREEZER
Violation Issued: No

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

THIS INSPECTION WAS CONDUCTED IN CONJUNCTION WITH MDH HEALTH REGULATORY DIVISION (HRD) SURVEY. SURVEYOR FROM HRD WAS MICHELLE WINTERS. INSPECTION CONDUCTED IN PRESENCE OF ABDI ABDI, THE PERSON IN CHARGE. ALL VIOLATIONS WERE DISCUSSED WITH THE HRD SURVEYOR AND PERSON IN CHARGE DURING INSPECTION.

THIS FACILITY DOES NOT HAVE COMMERCIAL GRADE ANSI EQUIPMENT. ALL FOOD MUST BE SERVED THE SAME DAY IT IS PREPARED, AND LEFTOVERS CAN NEVER BE SAVED.

DISCUSSED ALL ORDERS ON SITE IN ADDITION TO THE FOLLOWING WITH THE PERSIN IN CHARGE:
- EMPLOYEE ILLNESS LOG AND EXCLUSION POLICY.
- HAND WASHING POLICY AND REVIEW.
- PROPER FOOD STORAGE.
- GLOVE USAGE.
- THERMOMETER USE AND CALIBRATION.
- DATE MARKING.
- PEST CONTROL.
- FULLY COOKING FOOD FOR HIGH RISK POPULATIONS.
- ANSI 184 STANDARD FOR RESIDENTIAL DISH WASHER.

FOR CORRECT BY DATES REFER TO COMPLETE REPORT ISSUED BY HRD.

**IF ANY RESIDENT COMPLAINS OF ILLNESS, CONTACT THE MINNESOTA DEPARTMENT OF HEALTH AND PROVIDE THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER TO THE CUSTOMER. THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER IS 1-877-366-3455.

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

I acknowledge receipt of the inspection report number 1036241066 of 04/08/24.

Certified Food Protection Manager:______________________

Certification Number: __________ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed:______________________ Signed:______________________

ABDI ABDI
PERSON IN CHARGE (PIC)

Jeff Johanson