



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

May 8, 2024

Licensee
Horizon Care LLC
1075 Rome Drive
Apple Valley, MN 55124

RE: Project Number(s) SL35990015

Dear Licensee:

On April 18, 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 November 15, 2023. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the November 15, 2023 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 November 15, 2023, found not corrected at the time of the April 18, 2024, follow-up survey and/or subject to penalty assessment are as follows:

1500-Required Annual Training-144g.63 Subd. 5
1530-Training In Dementia Care Required-144g.64

The details of the violations noted at the time of this follow-up survey completed on April 18, 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.

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.

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>

We urge you to review these orders carefully. If you have questions, please contact Jodi Johnson at 507-344-2730.

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,



Jodi Johnson, Supervisor
State Evaluation Team
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35990	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 04/18/2024
NAME OF PROVIDER OR SUPPLIER HORIZON CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1075 ROME DRIVE APPLE VALLEY, MN 55124			
(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: SL35990015-2 On April 15, 2024, through April 18, 2024, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on February 13, 2024. At the time of the survey, there were 4 residents; all 4 receiving services under the Assisted Living license. As a result of the revisit, the following orders were reissued.	{0 000}	Minnesota Department of Health is documenting the State 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.		
{01500} SS=D	144G.63 Subd. 5 Required annual training	{01500}			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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{01500}	Continued From page 1 (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research	{01500}			

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{01500}	Continued From page 2 based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment for one of two employees (registered nurse (RN)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death),and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: RN-B RN-B started working for the licensee on June 16, 2022.	{01500}			

Minnesota Department of Health

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{01500}	Continued From page 3 RN-B's employee record contained annual training with a completion date of April 15, 2024, (the start of this survey). RN-B's employee record failed to show any previous training. RN-B's employee training records lacked evidence RN-B had successfully completed all annual training as required in the following area: -Assisted living Bill of Rights On April 17, 2024, at 11:23 a.m. housing manager (HM)-D stated the training had not been completed and he needed to set up a better tracking system to manage. The licensee's undated, Staff Orientation and Education policy, referencing homecare statute 144A, indicated all staff providing direct home care will complete at least 8 hours of education for every 12 months of employment. No further information was provided.	{01500}			
{01530} SS=E	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working	{01530}			

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{01530}	Continued From page 4 hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure three of three employees (unlicensed personnel (ULP)-C, registered nurse (RN)-B, ULP-E) received the required amount of dementia care training in the required time frame. 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-C ULP-C started working for the licensee July 9, 2022, to provide direct care services to the	{01530}			

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{01530}	Continued From page 5 residents. ULP-C's employee record indicated Dementia training was completed on the following dates: - January 3, 2024, totaling 1 hour - January 5, 2024, totaling 1 hour - January 25, 2024, totaling 1.75 hours; for a grand total of 3.75 hours. ULP-C's employee record failed to show evidence of at least eight hours of initial dementia training at hire and at least two hours of training for each twelve months of employment as required. RN-B RN-B started working for the licensee on June 16, 2022. RN-B's employee record indicated dementia training was completed on the following dates: -April 15, 2024, (after the start of the survey) eight classes totaling 6.75 hours RN-B's employee record failed to show evidence of at least eight hours of initial dementia training at hire and at least two hours of training for each twelve months of employment as required. ULP-E ULP-E started working for the licensee November 21, 2021, to provide direct care services to the residents. ULP-E's employee record indicated dementia training was completed on the following dates: - March 4, 2024, took seven dementia related classes totaling 6.25 hours - March 5, 2024, totaling 0.75 hours ULP-E's employee record failed to show evidence	{01530}			

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{01530}	Continued From page 6 of at least eight hours of initial dementia training at hire and at least two hours of training for each twelve months of employment as required. On April 17, 2024, at 2:39 p.m. housing manager (HM)-D indicated the employee files were missing the required amount of dementia training. The licensee's undated, Staff Orientation and Education policy, referencing homecare statute 144A, indicated the facility would provide training related to Alzheimer's disease. No further information was provided.	{01530}			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

March 12, 2024

Licensee
Horizon Care, LLC
1075 Rome Drive
Apple Valley, MN 55124

RE: Project Number(s) SL35990015

Dear Licensee:

On February 13, 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 November 15, 2023. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the November 15, 2023 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on November 15, 2023, found not corrected at the time of the February 13, 2024, follow-up survey and/or subject to penalty assessment are as follows:

0660-Tuberculosis Prevention And Control-144g.42 Subd. 9 - \$500.00
0680-Disaster Planning And Emergency Preparedness-144g.42 Subd. 10 - \$500.00
0810-Fire Protection And Physical Environment-144g.45 Subd. 2 (b)-(f) - \$500.00
1500-Required Annual Training-144g.63 Subd. 5 - \$500.00
1890-Prescription Drugs-144g.71 Subd. 20 - \$500.00

The details of the violations noted at the time of this follow-up survey completed on February 13, 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.

Also, at the time of this follow-up survey completed on February 13, 2024, we identified the following violation(s):

0340-Correction Orders-144g.30 Subd. 5 - \$500.00

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

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

DOCUMENTATION OF ACTION TO COMPLY

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

IMPOSITION OF FINES:

Level 1: no fines or enforcement.

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

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

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

To submit a reconsideration request, please visit:

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

REQUESTING A HEARING

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

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

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

We urge you to review these orders carefully. If you have questions, please contact Jodi Johnson at 507-344-2730.

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

Sincerely,

A handwritten signature in black ink, appearing to read "Jodi Johnson", with a long horizontal flourish extending to the right.

Jodi Johnson, Supervisor
State Evaluation Team
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

PMB

Minnesota Department of Health

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{0 000}	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER 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: SL35990015-1 On February 12, 2024, through February 13, 2024, the Minnesota Department of Health conducted a completed on revisit at the above provider to follow-up on orders issued pursuant to a survey November 15, 2023. At the time of the survey, there were five residents; five residents were receiving services under the Assisted Living license. As a result of the revisit, the following orders were reissued.	{0 000}	Minnesota Department of Health is documenting the State 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.		
0 340	144G.30 Subd. 5 Correction orders a) A correction order may be issued whenever the commissioner finds upon survey or during a	0 340			

Minnesota Department of Health

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

TITLE

(X6) DATE

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0 340	Continued From page 1 complaint investigation that a facility, a managerial official, an agent of the facility, or an employee of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail or email copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have sufficient documentation with actions taken to comply with the correction orders for a revisit survey completed on February 13, 2024. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that	0 340			

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0 340	Continued From page 2 has affected or has the potential to affect a large portion or all of the residents). The findings include: During the revisit survey on February 12, 2024, a review of the licensee's policies and procedures, resident records, and employee records lacked evidence to indicate the licensee had attempted to correct all the orders issued for the survey concluded on November 15, 2023. Reissued orders include: 0650, 0660, 0680, 0810, 0970, 1500, 1530, 1700, 1880 and 1890. On February 12, 2024, at 11:40 a.m. housing manager (HM)-D stated being unaware of the previous survey results and what needed correction. HM-D further stated licensed assisted living director (LALD)-A "handled that." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 340			
{0 650} SS=E	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency	{0 650}			

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER HORIZON CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1075 ROME DRIVE APPLE VALLEY, MN 55124		
(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 3 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 two of two employees records (unlicensed personnel (ULP)-C, ULP-E) contained performance evaluations. 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-C ULP-C began providing direct care services for the licensee on July 9, 2022. ULP-C's employee record contained a blank form	{0 650}			

Minnesota Department of Health

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{0 650}	Continued From page 4 labeled "Employee Performance Review." ULP-C's employee record lacked any completed performance evaluations. ULP-E ULP-E began providing direct care services for the licensee on November 21, 2021. On February 12, 2024, at 11:50 a.m. ULP-E was observed administering morning medications to R3. ULP-E's employee record contained a completed performance evaluation dated December 30, 2022. ULP-E's employee record failed to show evidence of any other completed performance evaluations. On February 12, 2024, at 3:08 p.m. housing manager (HM)-D, stated ULP-C and ULP-E's employee records were missing performance evaluations. The licensee's undated, Employee Records policy indicated employee records will include documentation of annual performance reviews, which identify area of improvement needed and training needs. No further information was provided.	{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	{0 660}			

Minnesota Department of Health

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{0 660}	Continued From page 5 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 ensure the provider established and maintained a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included completion of a facility risk assessment with all the required fields. 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: During the entrance conference on November 13, 2023, at 9:40 a.m. during the previous survey, the surveyor asked for the licensee's TB risk assessment.	{0 660}			

Minnesota Department of Health

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{0 660}	Continued From page 6 The licensee's TB Risk Assessment Worksheet for Health Care Settings dated November 15, 2023, failed to show evidence the incidence of TB section was completed and failed to show evidence a TB risk level for this setting was completed. On February 12, 2024, at 1:40 p.m. housing manager (HM)-D stated he was unaware of this requirement and it had not been fixed. The licensee's Tuberculosis Prevention & Screening Plan dated April 8, 2017, indicated a committee will consist of a registered nurse, director, chief operating office, and admin staff and the committee with ensure a risk assessment is completed at least every two years. The Minnesota Department of Health (MDH) guidelines "Regulations for Tuberculosis Control in Minnesota Health Care Settings" dated July 2013, and based on CDC guidelines, indicated a TB risk assessment should be completed initially and then for low-risk settings the risk assessment should be updated every other year; each agency should have written TB infection control procedures. No further information was provided.	{0 660}			
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff	{0 680}			

Minnesota Department of Health

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{0 680}	Continued From page 7 assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop an all-hazards risk assessment emergency preparedness program and plan to include Appendix Z required elements. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include:	{0 680}			

Minnesota Department of Health

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{0 680}	Continued From page 8 During the entrance conference on February 12, 2024, at 10:20 a.m., the surveyor asked for the licensee's emergency preparedness plan (EPP). The EPP manual consisted of a binder of written policies and written example of creating an all-hazards vulnerability assessment, but lacked customization to the facility needs and hazards. The licensee's plan lacked an all-hazards vulnerability assessment, in addition to the following required content: - Identify at risk patient population - process for EP collaboration - subsistence needs for staff and patients - procedure for tracking staff and residents. - policy and procedures including evacuation and sheltering in place - policies and procedures to address role of facility under a waiver declared by the Secretary in accordance with section 1135 of the Act - development of a communication plan - emergency officials contact information - EP testing/annual testing requirements. On February 12, 2024, at 1:30 p.m. assistant director (AD)-A contacted LALD-A by phone and stated they had ordered it from an organizational group, but it had not been received yet. The licensee's undated, Emergency Preparedness policy referenced 144A Homecare regulations. The policy indicated the facility will have an identified plan in place to assure the safety and well-being of clients and staff during periods of an emergency or disaster that disrupts services. No further information was provided.	{0 680}			

Minnesota Department of Health

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{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, record review, and	{0 810}			

Minnesota Department of Health

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{0 810}	Continued From page 10 interview, the licensee failed to develop a fire safety and evacuation plan with the required content, and provide the required training. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On February 13, 2024, at 3:15 p.m., survey staff toured the home with house manager (HM)-D. During the tour, survey staff observed the posted emergency evacuation maps did not identify the resident sleeping room numbers. During the facility tour interview, HM-D verified the resident room numbers were missing. On February 13, 2024, HM-D provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and employee evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The FSEP Fire Safety Policy dated August 1, 2021, was a template and had not been developed for use at this facility. The fire safety policy 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 employee	{0 810}			

Minnesota Department of Health

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{0 810}	Continued From page 11 actions for fire were limited to the acronym RACE (Remove, Alarm, Confine, and Extinguish or Evacuate). The fire safety policy did not identify specific fire protection procedures for residents evident by limited instructions directing residents to stoop or crawl to avoid smoke. No additional fire protection procedures necessary for residents were included. During an interview on February 13, 2024, at 4:00 p.m., HM-D stated the FSEP was in the process of being revised. TRAINING Record review indicated the licensee failed to provide fire safety and evacuation training to residents at least once per year as evident by the lack of training documentation to support that this training had been completed. During an interview on February 13, 2024, at 4:00 p.m., HM-D stated residents had been trained but this was not recorded.	{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:	{0 970}			

Minnesota Department of Health

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{0 970}	Continued From page 12 Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident. This had the potential to affect all five residents living within the assisted living facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2 was admitted on May 12, 2022, with a diagnosis of major depressive disorder and anxiety. R2's signed contract on May 12, 2023, included a clause section 23 identified as "Indemnification", which read "the tenant will indemnify and hold harmless Landlord, its employees and agents from and against any and all claims, actions, damages, and liability and expense in connection with loss of life, personal injury or damage to property, arising from or out of the use by tenant of the rented premises or any other part of landlord's property, or caused wholly or in part by an act or omission of tenant or tenants guests or agents." On February 12, 2024, at 11:30 a.m. housing director (HD)-D stated he was unaware that contracts needed to be redone.	{0 970}			

Minnesota Department of Health

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{0 970}	Continued From page 13 No further information was provided.	{0 970}			
{01500} SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a),	{01500}			

Minnesota Department of Health

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{01500}	Continued From page 14 annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment for two of two employees (unlicensed personnel (ULP)-C, ULP-E). 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:	{01500}			

Minnesota Department of Health

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{01500}	Continued From page 15 ULP-C ULP-C started working for the licensee on July 9, 2022, to provide direct care services to residents. ULP-C's employee record contained annual training with completion dates from November 19, 2023, through January 25, 2024. ULP-C's employee training records lacked evidence ULP-C had successfully completed all annual training as required in the following areas: - Training on reporting of maltreatment of vulnerable adults under section 626.557; - Review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; and - Review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures. ULP-E ULP-E started working for the licensee November 21, 2021, to provide direct care services to residents. ULP-E's employee record contained orientation training from December 1, 2021, through December 11, 2021. ULP-E's employee record contained annual training with completion dates on January 26, 2024, and January 28, 2024. ULP-E's employee training records lacked evidence ULP-E had successfully completed all annual training as required in the following areas: - Training on reporting of maltreatment of	{01500}			

Minnesota Department of Health

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{01500}	Continued From page 16 vulnerable adults under section 626.557; - Review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; - Review of infection control techniques used the home and implementation of infection control standards; - Review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and - principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. On February 8, 2024, at 3:08 p.m. housing manager (HM)-D stated the annual training had not been completed and stated she was currently working on the trainings. The licensee's undated, Staff Orientation and Education policy, referencing Homecare statute 144A, indicated all staff providing direct home care will complete at least 8 hours of education for every 12 months of employment. No further information was provided.	{01500}			
{01530} SS=D	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of	{01530}			

Minnesota Department of Health

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{01530}	Continued From page 17 employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of two employees unlicensed personnel (ULP)-E received the required amount of dementia care training in the required time frame. 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-E started working for the licensee November	{01530}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35990	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 02/13/2024
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{01530}	Continued From page 18 21, 2021, to provide direct care services to residents. ULP-E's employee record contained five hours of completed dementia training on December 5, 2021, and a half hour of completed dementia training on January 26, 2024. No other dementia training was completed. On February 12, 2024, at 11:30 a.m. ULP-E was observed administering morning medications to R3. On February 8, 2024, at 3:08 p.m. housing manager (HM)-D stated ULP-E had not completed the required training and was currently working on completing. The licensee's undated, Staff Orientation and Education policy, referencing homecare statute 144A, indicated the facility would provide training related to Alzheimer's disease. No further information was provided.	{01530}			
{01700} SS=D	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the	{01700}			

Minnesota Department of Health

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{01700}	Continued From page 19 resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure residents were assessed for self-administration of medications for one of two residents (R3) who self-administered medications. 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: R3 was admitted to the facility on July 20, 2022, for assistance with medication management and reminders for activities of daily living (ADLs).	{01700}			

Minnesota Department of Health

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{01700}	Continued From page 20 R3's diagnoses included schizophrenia and diabetes. R3's nurse reassessment dated January 21, 2024, indicated the licensee provided medication management. R3's medical record showed no evidence of R3 was assessed for safety of self-administration of an inhaler. On February 12, 2024, at 11:50 a.m. unlicensed personal (ULP)-E was observed handing R3 his inhaler to self-administer. R3 administered the inhaler and when finished returned the inhaler to ULP-E. On February 12, 2024, at 11:40 a.m. housing manager (HM)-D stated being unaware of the previous survey results and what needed correction. HM-D further stated licensed assisted living director (LALD)-A "handled that." The licensee's undated, Medication Administration policy outlining statute 144A for Homecare regulations, indicated medications will be administered by a nurse, physician or other licensed health practitioner authorized to administer medications. No further information was provided.	{01700}			
{01880} SS=D	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and	{01880}			

Minnesota Department of Health

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{01880}	Continued From page 21 permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure refrigerated medications were stored at the appropriate temperature in the licensee's one medication refrigerator. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: On February 12, 2024, at 11:00 a.m. the surveyor reviewed the medication refrigerator with unlicensed personal (ULP)-E and housing manager (HM)-D. HM-D stated it was the expectation to record the refrigerator temperature daily. The refrigerator was locked, and a temperature log was taped on the outside of the door. The log contained daily temperatures within range, from February 1-7, 2024. The refrigerator contained a box of Victoza. The licensee failed to show evidence of any recorded temperatures from February 8, 2024, through February 12, 2024. Manufacture guidelines for Victoza dated January 2010, indicated Victoza should be stored in a	{01880}			

Minnesota Department of Health

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{01880}	Continued From page 22 refrigerator between 36°F to 46°F. Do not freeze. The license's undated, Storage/Control of Medications Policy indicated refrigerated medications will be stored separately in an enclosed container or area separated from foods. Medications must be clearly labeled and stored at a temperature of 35 to 40 degrees. No further information was provided.	{01880}			
{01890} SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were maintained bearing the original prescription label with legible information including the expiration date for time sensitive medications for one of one resident (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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).	{01890}			

Minnesota Department of Health

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{01890}	Continued From page 23 The findings include: R3 was admitted to the facility on July 20, 2022, for assistance with medication management and reminders for activities of daily living (ADLs). R3's February 2024, electronic medical record (EMR) indicated R3 took Combivent Respimat aerosol inhaler four times a day (prevents narrowing of the airways). On February 12, 2024, at 11:50 a.m. the surveyor observed unlicensed personal (ULP)-E assisting R3 with his morning medications. ULP-C handed the Combivent inhaler to R3 to self-administer. The licensee failed to place an expiration date or beyond-use date of a time-dated drug. ULP-E confirmed the Combivent inhaler lacked a expiration label and was not aware it was required. On February 12, 2024, at 12:00 p.m. housing manager (HM)-D stated being unaware of the requirement. The manufacturer's instructions for Combivent inhaler dated December 2021, indicated Combivent inhaler should be discarded after 3 months of assembly. The license's undated, Storage/Control of Medications Policy indicated medication will be stored in accordance with the manufacturer's guidelines. No further information was provided.	{01890}			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

December 14, 2023

Licensee
Horizon Care LLC
1075 Rome Drive
Apple Valley, MN 55124

RE: Project Number(s) SL35990015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on November 15, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the 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. The MDH documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

IMPOSITION OF FINES

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

Level 1: no fines or enforcement.

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

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

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

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5), the MDH may impose fine amounts of either \$1,000 or \$5,000 to licensees who are found to be responsible for maltreatment. The MDH may impose a fine of \$1,000 for each substantiated maltreatment violation that consists of

abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The MDH also may impose a fine of \$5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

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

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

St - 0 - 0820 - 144g.45 Subd. 2 (g) - Fire Protection And Physical Environment - \$3,000.00

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

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

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

REQUESTING A HEARING

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

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

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

If you have any questions, please contact me.

Sincerely,



Jodi Johnson, Supervisor
State Evaluation Team
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

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0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL35990015 On November 13, 2023, through November 15, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were five active residents; all five receiving services under the Assisted Living license. 0820: An immediate correction order was identified and removed on November 13, 2023, however non-compliance remained at a level 3, widespread (I). 2310: An immediate correction order was identified and removed on November 14, 2023, however non-compliance remained at a level 2, widespread (F).	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.		

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 250	Continued From page 1	0 250			
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department;	0 250			

Minnesota Department of Health

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0 250	Continued From page 2 (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to demonstrate they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required with records reviewed. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 250			

Minnesota Department of Health

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0 250	Continued From page 3 The findings include: During the entrance conference on November 13, 2023, at 9:40 a.m., assistant director (AD)-A stated the facility was familiar with the assisted living regulations and the licensee provided medication and treatment management services. The licensee's Application for Assisted Living License, section titled Official Verification of Owner or Authorized Agent identified, I certify I have read and understand the following: [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17. - I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G. - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659. - Reporting of Maltreatment of Vulnerable Adults. - Electronic Monitoring in Certain Facilities - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or	0 250			

Minnesota Department of Health

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0 250	Continued From page 4 misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license. - I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. - I have examined this application and all attachments and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required. - I attest to have all required policies and	0 250			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35990	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/15/2023
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0 250	Continued From page 5 procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page six was electronically signed by AD-A on September 27, 2023. The licensee had an assisted living license reissued on November 1, 2023, with an expiration date of October 31, 2024. The licensee failed to ensure the following policies and procedures were developed and implemented for Assisted Living Statute 144G: - orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; - conducting initial evaluations of residents' needs and the providers' ability to provide these services; - conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; - orientation to and implementation of the assisted living bill of rights; - conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; and - medication and treatment management As a result of this survey, the following orders were issued: 0650, 660, 1370, 1470, 1500, 1530, 1610, 1830, 1870, 1880, 1890, 2310, indicating the licensee's understanding of the Minnesota	0 250			

Minnesota Department of Health

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0 250	Continued From page 6 statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. In addition, the provider's policies reflected Home Care statutes under 144A, instead of Assisted Living statutes under 144G, as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250			
0 430 SS=C	144G.40 Subd. 2 Uniform checklist disclosure of services (a) All assisted living facilities must provide to prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a). This MN Requirement is not met as evidenced	0 430			

Minnesota Department of Health

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0 430	Continued From page 7 by: Based on interview and record review, the licensee failed to have a Uniform Disclosure of Assisted Living Service and Amenities (UDALSA) as required. This had the potential to affect all residents living in the facility. 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: R1 with admitted on May 12, 2022, with a diagnosis of major depressive disorder and anxiety. R1's record lacked evidence of being provided with the UDALSA. On November 14, 2023, at 10:30 a.m. assistant director (AD)-A stated the files do not contain a UDALSA. The licensee's undated, Notifications Policy referencing Statute 144A (homecare licensing), failed to indicate the UDALSA would be provided at the time of initiating services. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 430			

Minnesota Department of Health

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0 480	Continued From page 8	0 480			
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated November 13, 2023, 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			
0 650 SS=D	144G.42 Subd. 8 Employee records	0 650			

Minnesota Department of Health

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0 650	Continued From page 9 (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 one of one employee records (unlicensed personnel (ULP)-C) contained a performance evaluation. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).	0 650			

Minnesota Department of Health

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0 650	Continued From page 10 The findings include: ULP-C began providing direct care services for the licensee on July 9, 2022. On November 14, 2023, at 10:30 a.m. ULP-C was observed administering morning medications to residents. ULP-C's employee record lacked evidence of a completed annual performance evaluation. On November 15, 2023, at 10:15 a.m. assistant director (AD)-A stated ULP-C's employee record contained a blank copy of the performance evaluation, and he was not aware it had not been completed. The licensee's undated, Employee Records policy indicated employee records will include documentation of annual performance reviews, which identify area of improvement needed and training needs. 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	0 660			

Minnesota Department of Health

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0 660	Continued From page 11 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 ensure the provider established and maintained a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included completion of a facility risk assessment. 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: During the entrance conference on November 13, 2023, at 9:40 a.m., the surveyor asked for the licensee's TB risk assessment and assistant director (AD)-A stated he was not aware a risk assessment was needed. The licensee's Tuberculosis Prevention & Screening Plan dated April 8, 2017, indicated a	0 660			

Minnesota Department of Health

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0 660	Continued From page 12 committee will consist of a registered nurse, director, chief operating office, and admin staff and the committee with ensure a risk assessment is completed at least every two years. The MN Department of Health Facility Tuberculosis (TB) Risk Assessment Instructions and Worksheet for Health Care Setting Licensed by MDH updated June 2023, indicated: Settings should perform a facility risk assessment on an annual basis. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually	0 680			

Minnesota Department of Health

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0 680	Continued From page 13 available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to develop an all-hazards risk assessment emergency preparedness program and plan to include Appendix Z required elements. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: During the entrance conference on November 13, 2023, at 9:40 a.m., the surveyor asked for the licensee's emergency preparedness plan (EPP). Assistant director (AD)-A stated he completed it in class and later provided to the surveyor. The EPP manual consisted of a binder of written policies and a written example of creating an all-hazards vulnerability assessment, but lacked customization to the facility needs and hazards. The licensee's plan lacked an all-hazards	0 680			

Minnesota Department of Health

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0 680	Continued From page 14 vulnerability assessment in addition to the following required content: - Identify at risk patient population - process for EP collaboration - subsistence needs for staff and patients - procedure for tracking staff and residents. - policy and procedures including evacuation and sheltering in place - policies and procedures to address role of facility under a waiver declared by the Secretary in accordance with section 1135 of the Act - development of a communication plan - emergency officials contact information - EP testing/annual testing requirements. On November 15, 2023, at 11:15 a.m. AD-A stated the emergency preparedness manual did not have all the elements required. The licensee's undated, Emergency Preparedness policy referenced 144A Homecare regulations. The policy indicated the facility will have an identified plan in place to assure the safety and well-being of clients and staff during periods of an emergency or disaster that disrupts services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680			
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;	0 790			

Minnesota Department of Health

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0 790	Continued From page 15 (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 install and maintain the portable fire extinguishers as required by statute. This deficient condition had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 November 13, 2023, at 1:00 p.m., survey staff toured the home with assistant director (AD)-A. During the tour, survey staff observed the following: 1. Tags or labels were not attached to the portable fire extinguisher showing monthly fire extinguisher inspections were completed. Fire extinguisher inspections must be conducted every month to ensure each extinguisher is in its designated place, it has not been tampered with,	0 790			

Minnesota Department of Health

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0 790	Continued From page 16 and there is no obvious physical damage or condition that would interfere with its use or operation. 2. In the basement, a portable fire extinguisher was not installed. The travel distance to the nearest fire extinguisher exceeded 75 feet. During an interview on November 14, 2023, at 3:00 p.m., AD-A verified these deficient conditions. 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. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 800			

Minnesota Department of Health

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0 800	Continued From page 17 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 November 13, 2023, at 1:00 p.m., survey staff toured the home with assistant director (AD)-A. During the tour, survey staff observed the following: 1. The door leading into the garage from the home had an exit sign posted over it and was designated as an exit on the emergency evacuation map. Emergency exits are required to lead directly to the exterior of the building and not through a higher hazard room. 2. The path to the egress window was obstructed by a TV console and personal items in bedroom 4, occupied by R4. The path to the egress window was obstructed by a desk and personal items in bedroom 2, occupied by R2. The improper placement of furniture and personal items could delay exiting in the event of an emergency. 3. In the backyard of the resident outdoor space, one of the fence gates was held shut by a bungee cord. When the bungee cord was removed, the gate fell and did not operate properly, posing a safety risk to residents. 4. Two light bulbs were not working in the light fixture above the sink in the resident's bathroom located in the basement. During an interview on November 14, 2023, at	0 800			

Minnesota Department of Health

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0 800	Continued From page 18 3:00 p.m., AD-A verified these deficient conditions. 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 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	0 810			

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER HORIZON CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1075 ROME DRIVE APPLE VALLEY, MN 55124		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 810	Continued From page 19 activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to develop fire safety and evacuation plans 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). The findings include: On November 13, 2023, at 1:00 p.m., survey staff toured the home with assistant director (AD)-A. During the tour, survey staff did not observe a fire alarm panel or pull fire alarms. On November 14, 2023, AD-A provided documents on the fire safety and evacuation plans (FSEP), fire safety and evacuation training, and employee evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLANS The facility diagram and evacuation plan sections were blank in the undated Emergency Preparedness Manual. Templates were being used that had not been developed for the facility. The Contingency Review of Fire Safety dated August 12, 2023, was a template and had not been developed for use at this facility. The protocol directed employees to pull the nearest fire alarm and to check the fire panel in the lobby. A fire panel and pull fire alarms were not	0 810			

Minnesota Department of Health

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0 810	Continued From page 20 observed during the facility tour. The protocol directs employees to move residents to a location beyond a fire door, but the fire door location is not identified. The Fire Safety Policy dated August 1, 2021, was a template and had not been developed for use at this facility. The fire safety policy 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 fire safety policy did not identify specific fire protection procedures for residents evident by limited instructions directing residents to stoop or crawl to avoid smoke. No additional fire protection procedures necessary for residents were included. The fire safety policy directs employees to evacuate residents from the building but failed to include information on where residents should relocate to in the event of a fire. During an interview on November 14, 2023, at 3:00 p.m., AD-A explained residents would relocate to the parking lot in the event of an evacuation and confirmed that template plans were being used. TRAINING Record review indicated the licensee failed to provide training to employees on the FSEP upon hire and/or at least twice per year as evident by the lack of training documentation. One training record was provided dated August 12, 2023, but this record did not list the names of the employees who participated. There was a handwritten note on the training record stating all employees attended. Additional employee training records were provided from EduCare on emergency preparedness, but this training was not specific to	0 810			

Minnesota Department of Health

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0 810	Continued From page 21 the facility's fire safety and evacuation plans. Record review indicated the licensee failed to provide fire safety and evacuation training to residents at least once per year as evident by the lack of training documentation to support that this training had been completed. One training record was provided dated August 12, 2023, but this record did not list the names of the residents who participated. There was a handwritten note on the training record stating all residents attended. During an interview on November 14, 2023, at 3:00 p.m., AD-A explained employees received training on the facility fire safety and evacuation plan upon hire and annually. AD-A stated residents were trained upon admission and during every fire drill. DRILLS Record review indicated the licensee failed to provide documentation to support employee evacuation drills had been completed twice per year, per shift with at least one evacuation drill every other month as evident by fire drill reports lacking the required information. Monthly fire drill reports were provided between August 2021 and October 2023. The names of the employees who participated in these drills had only been recorded on one drill record dated 08/21/2021. During an interview on November 14, 2023, at 3:00 p.m., AD-A explained the name of the caregiver conducting the fire drill was always recorded but the licensee had not documented which employees and residents had participated. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
0 820 SS=I	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including	0 820			

Minnesota Department of Health

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0 820	Continued From page 22 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 the minimum height opening and total clear openable area for egress windows in four occupied resident bedrooms. This had the potential to directly affect four residents and all staff. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at 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 November 13, 2023, at 1:00 p.m., survey staff toured the home with the assistant director (AD)-A. The egress windows in all of the resident bedrooms were opened and measured by AD-A. The bedroom windows for R2, R3, R4, and R5	0 820	This immediate correction order identified on November 13, 2023, has had the immediacy lifted as of November 14, 2023, by assigning a fire watch for the facility. This was confirmed by the licensee via email and approved by evaluation supervisor.		

Minnesota Department of Health

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0 820	Continued From page 23 did not meet the minimum egress window opening height and total clear openable area required for safe egress. Egress window measurements: Bedroom 2, occupied by R2 - 17.5"Hx25"W with a total clear openable area of 437.5 square inches Bedroom 3, occupied by R3 - 17"Hx33"W with a total clear openable area of 561 square inches Bedroom 4, occupied by R4 - 14"Hx30"W with a total clear openable area of 420 square inches Bedroom 5, occupied by R5 - 14"Hx34"W with a total clear openable area of 476 square inches One window in each resident bedroom must meet the minimum window opening size of at least 20 inches in height and, a minimum width of 20 inches, with a total of at least 648 square inches (4.5 square feet). These deficient conditions were verified by the AD-A during an interview with survey staff on November 13, 2023, at the end of the facility tour. TIME PERIOD FOR CORRECTION: Immediate	0 820			
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	0 970			

Minnesota Department of Health

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0 970	Continued From page 24 by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident. This had the potential to affect all residents living within the assisted living facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2 with admitted on May 12, 2022, with a diagnosis of major depressive disorder and anxiety. R2's signed contract on May 12, 2023, included a clause section 23 identified as Indemnification. Stating the tenant will indemnify and hold harmless Landlord, its employees and agents from and against any and all claims, actions, damages, and liability and expense in connection with loss of life, personal injury or damage to property, arising from or out of the use by tenant of the rented premises or any other part of landlord's property, or caused wholly or in part by an act or omission of tenant or tenants guests or agents. On November 15, 2023, at 11:15 a.m. assistant director (AD)-A stated R2's contract contained indemnification language holding the facility	0 970			

Minnesota Department of Health

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0 970	Continued From page 25 harmless and was not aware that it was there. AD-A further indicated the same contract was used for all residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970			
01370 SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to 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	01370			

Minnesota Department of Health

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01370	Continued From page 26 the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of one unlicensed personnel (ULP-C) completed training and competency evaluations in all required training topics. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-C began providing direct care services for the licensee on July 9, 2022. On November 14, 2023, at 10:30 a.m. ULP-C was observed administering morning medications to residents. ULP-C employee record lacked evidence of training for the following topics.	01370			

Minnesota Department of Health

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01370	Continued From page 27 - documentation requirements for all services provided; - reports of changes in the resident's condition to the supervisor designated by the facility; - maintenance of a clean and safe environment; - 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 (iv) dressing and assisting with toileting - training on the prevention of falls; - awareness of confidentiality and privacy; and - awareness of commonly used health technology equipment and assistive devices. On November 14, 2023, at 3:21 p.m. assistant director (AD)-A stated he was aware ULP-C's employee record lacked the required training. The licensee's undated, Staff Orientation and Education policy, referencing Homecare statute 144A, indicated no one may provide direct care to clients on behalf of the facility before successfully completing the organizations program (training). No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01370			
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	01470			

Minnesota Department of Health

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01470	Continued From page 28 of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must 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;	01470			

Minnesota Department of Health

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01470	Continued From page 29 (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 review, the licensee failed to ensure orientation to assisted living facility licensing requirements and regulations for one of one employee (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-C was hired on July 9, 2022, to provide direct care services to residents at the assisted living facility. On November 14, 2023, at 10:30 a.m. ULP-C was observed administering morning medications to residents. ULP-C's employee record contained orientation	01470			

Minnesota Department of Health

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01470	Continued From page 30 training for statute 144A Home Care services and the home care bill of rights that was completed July 2022. ULP-C's employee records lacked the following required orientation content: - overview of the 144G Assisted Living Statutes - compliance with and reporting of the maltreatment of vulnerable adults - Assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights. - principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; and - review of the type of assisted living services the employee will be providing and the facilities category of licensure. On November 14, 2023, at 3:21 p.m. assistant director (AD)-A stated ULP-C's employee record lacked the required orientation and annual training. The licensee's undated, Staff Orientation and Education policy, referencing Homecare statute 144A, indicated orientation topics would include and not limited to. -overview of Minnesota Home Care Statute 144A -Review of the employee job description -Review of organization's policies and procedures related to home care services. -handling of emergencies -compliance with Minnesota Vulnerable adult/minor acts -home care bill of rights -grievance policy/process -consumer advocacy services	01470			

Minnesota Department of Health

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01470	Continued From page 31 No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470			
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning	01500			

Minnesota Department of Health

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01500	Continued From page 32 and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment for one of one employee (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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	01500			

Minnesota Department of Health

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01500	Continued From page 33 situation has occurred only occasionally). The findings include: ULP-C started working for the facility on July 9, 2022. ULP-C's employee training records lacked evidence ULP-E had successfully completed annual training as required in the following areas: - Training on reporting of maltreatment of vulnerable adults under section 626.557. - Review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights. - Review of infection control techniques. - Review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and - The principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. On November 14, 2023, at 3:21 p.m. assistant director (AD)-A stated ULP-C's employee record lacked the required annual training. The licensee's undated, Staff Orientation and Education policy, referencing Homecare statute 144A, indicated all staff providing direct home care will complete at least 8 hours of education for every 12 months of employment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35990	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/15/2023
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01530	Continued From page 34	01530			
01530 SS=D	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of one employee (unlicensed personnel (ULP)-C) received the required amount of dementia care training in the required time frame. This practice resulted in a level two violation (a violation that did not harm a resident's health or	01530			

Minnesota Department of Health

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01530	Continued From page 35 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-C was hired on July 9, 2022, to provide direct care services to residents at the assisted living facility. On November 14, 2023, at 10:30 a.m. ULP-C was observed administering morning medications to residents. ULP-C's employee record contained 1.25 hours of dementia training completed on July 24, 2022. No other dementia training was completed. On November 14, 2023, at 3:21 p.m. assistant director (AD)-A stated ULP-C's employee record lacked the required annual training. The licensee's undated, Staff Orientation and Education policy, referencing Homecare statute 144A, indicated the facility would provide training related to Alzheimer's disease. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530			
01610 SS=D	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring	01610			

Minnesota Department of Health

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01610	Continued From page 36 (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan 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. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN) conducted an initial assessment for one of three residents (R1) as required. 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 diagnosis included anxiety, schizoaffective disorder, and bipolar disorder.	01610			

Minnesota Department of Health

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01610	Continued From page 37 R1 started receiving services from the licensee on March 20, 2022, to assist with cueing and reminders for activities of daily living (ADLs), medication administration, laundry, and housekeeping. R1's record indicated the initial assessment and care plan were completed on March 21, 2022. (One day after the initiation of services). On November 14, 2023, at 10:30 a.m. registered nurse (RN)-B reviewed R1's record and stated R1's initial assessment was completed one day after the admission date. The licensee's undated, Assessment-Comprehensive Services policy referenced statute 144A for Homecare services and not 144G for assisted living services. The policy indicated an initial assessment must be completed within five days of the initiation of services. If the assessment is not completed on initiation of services, a temporary plan and agreement with the client may be established until the assessment is completed. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01610			
01700 SS=D	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional,	01700			

Minnesota Department of Health

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01700	Continued From page 38 or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure residents were assessed for self-administration of medications for one of two residents (R3) who self-administered medications. 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	01700			

Minnesota Department of Health

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01700	Continued From page 39 situation has occurred only occasionally). The findings include: R3 was admitted to facility July 20, 2022, for assistance with medication management and reminders for activities of daily living (ADLs). R3's diagnoses included schizophrenia and diabetes. On November 14, 2023, at 8:30 a.m. the surveyor observed unlicensed personal (ULP)-C administering morning medication to R3 and handing a Victoza pen (anti-diabetic) to R3. R3 dialed up the pen to the correct dose and correctly self-administered. On November 14, 2023, at 10:30 a.m. registered nurse (RN)-B stated the resident's record did not contain a medication assessment indicating R3 could administer his own medication. The licensee's undated, Medication Administration policy outlining statute 144A for Homecare regulations, indicated medications will be administered by a nurse, physician or other licensed health practitioner authorized to administer medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700			
01830 SS=D	144G.71 Subd. 14 Renewal of prescriptions Prescriptions must be renewed at least every 12 months or more frequently as indicated by the	01830			

Minnesota Department of Health

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01830	Continued From page 40 assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure prescriptions were renewed at least every 12 months for one of three 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, 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 with admitted on May 12, 2022, with a diagnosis of major depressive disorder and anxiety. On November 14, 2023, at 8:30 a.m. the surveyor observed unlicensed personal (ULP)-C administering morning medication to R2. R2's November 2023, electronic medical record indicated the resident was on the following medications: Aspirin 81 milligrams (mg) duloxetine 30 mg (for depression) Folic Acid 1 mg Metoprol 25 mg (for high blood pressure) Pregabalin 75 mg (for anxiety)	01830			

Minnesota Department of Health

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01830	Continued From page 41 R2's record contained signed physician orders for May 12, 2022, the date of admission. R2's record lacked evidence of a current annual prescription renewal within the last twelve months. On November 14, 2023, at 2:10 p.m. assistant director (AD)-A stated they did not have annual medication orders for R2. AD-A stated the resident has told his physician to not share anything with the facility. The licensee's undated, Physician's Orders Policy indicated all medication prescriptions will be renewed every 12 months or sooner as required by the physician. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01830			
01880 SS=D	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of one refrigerated medication was securely locked permitting only authorized personnel to have access. This had the potential to affect all residents residing in the facility. In addition, the	01880			

Minnesota Department of Health

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01880	Continued From page 42 licensee failed to ensure refrigerated medications were stored at the appropriate temperature. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R3 was admitted to facility on July 20, 2022, for assistance with medication management and reminders for activities of daily living (ADLs). R3's medication list dated November 14, 2023, indicated he took Victoza 0.6 milligrams daily. On November 14, 2023, at 8:30 a.m. the surveyor observed unlicensed personal (ULP)-C assisting R3 with his morning medications. ULP-C went into the kitchen refrigerator where food was stored, took out a box of Victoza and handed the pen to R3 to administer on his own. The kitchen refrigerator did not have a lock and was accessible to all residents and staff. ULP-C stated they did not check the refrigerator temperatures. The refrigerator did not contain a thermometer or a temperature logbook. On November 14, 2023, at 11:30 a.m. assistant director (AD)-A stated he was unaware the refrigerator needed to be locked. The license's undated, Storage/Control of Medications Policy indicated refrigerated	01880			

Minnesota Department of Health

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01880	Continued From page 43 medications will be stored separately in an enclosed container or area separated from foods. Medications must be clearly labeled and stored at a temperature of 35 to 40 degrees. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880			
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were maintained bearing the original prescription label with legible information including the expiration date for time sensitive medications for one of one resident (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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:	01890			

Minnesota Department of Health

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01890	Continued From page 44 R3 was admitted to the facility on July 20, 2022, for assistance with medication management and reminders for activities of daily living (ADLs). R3's medication list dated November 14, 2023, indicated he took Victoza 0.6 milligrams (anti-diabetic) daily. On November 14, 2023, at 8:30 a.m. the surveyor observed unlicensed personal (ULP)-C assist R3 with his morning medications. ULP-C went into the kitchen refrigerator, took out a box of Victoza and handed an unlabeled pen to R3 to administer independently. On November 14, 2023, at 11:30 a.m. assistant director (AD)-A stated the Victoza pen did not have a label with the expiration date on it. The manufacturer's instructions for Victoza pens dated July 2022, directed to discard the pen 30 days after it had been opened. The license's undated, Storage/Control of Medications Policy indicated medication will be stored in accordance with the manufacturer's guidelines. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			
02310 SS=F	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the	02310			

Minnesota Department of Health

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02310	Continued From page 45 resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure care and services were provided according to acceptable health care and medical or nursing standards for one of one resident (R1) with siderails. This resulted in an immediate correction order on November 14, 2023, at approximately 10:15 a.m. This practice resulted in a level two violation (a violation that did not harm a client/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 began receiving services on March 20, 2022, under the facility's assisted living license. R1's diagnoses included anxiety, schizoaffective disorder, and depressive disorder. R1's Service Plan dated July 10, 2023, indicated she received services to include medication administration, and cuing and stand by assistance with activities of daily living (ADL). On November 13, 2023, at 10:30 am during the entrance tour with assistant director (AD)-A, the surveyor observed R1's room contained a hospital bed with top siderails in the up position	02310			

Minnesota Department of Health

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02310	Continued From page 46 on both sides of the bed. R1's record included a siderail assessment dated July 10,2023. The document lacked evidence of siderail measurements. On November 14, 2023, at 10:00 a.m. AD-A and registered nurse (RN)-B stated they were not aware siderail measurements were required and did not complete any for the bed. The March 10, 2006, FDA Side Rail Entrapment Zones and Dimensional Recommendations indicated to reduce the risk of entrapment, zone 1 (space between the rails), should be less than four and three quarters' inches. The Food and Drug Administration (FDA), "A Guide to Bed Safety," revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The licensee's undated, Use of Siderail Policy indicated the RN should ensure safety of the resident and that the resident/family should co-sign they have reviewed the risk versus benefits of use. The licensee's Bed Rails policy revised June 2022, indicated bed rails are only used when an	02310			

Minnesota Department of Health

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02310	Continued From page 47 assessment shows the benefit to the resident outweighs the risk of using a bedrail. The policy also indicates the person applying the bed rails to the bed must check to assure there are no gaps between the rail and the mattress or within the rails that is large enough to cause increased risk of injury. The policy does not address taking measurements of the bed rail. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate On November 14, 2023, at 1:22 p.m. the immediacy was lifted; however, non-compliance remained at a scope and level of I.	02310			

Type: Full
Date: 11/13/23
Time: 12:31:44
Report: 1004231194

Food and Beverage Establishment Inspection Report

Page 1

Location:

Horizon Care Llc
1075 Rome Drive
Apple Valley, MN55124
Dakota County, 19

Establishment Info:

ID #: 0037995
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7635015314
ID #:

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

The following orders were issued during this inspection.

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

3-302.11A(1) **** Priority 1 ****

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

RAW SHELL EGGS FOUND STORED OVER READY-TO-EAT ITEMS AND PRODUCE IN THE REFRIGERATOR. DISCUSSED REQUIRED STORAGE ORDER OF FOOD ITEMS WHEN RAW ANIMAL FOODS ARE PRESENT. ESTABLISHMENT WILL CLEAR OUT BOTTOM DRAW AND DESIGNATE FOR RAW ITEMS.

Comply By: 11/13/23

3-500B Microbial Control: hot and cold holding

3-501.16A2 **** Priority 1 ****

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

ITEMS IN THE REFRIGERATOR MEASURED BETWEEN 46-52°F. TCS ITEMS WERE DISCARDED DURING INSPECTION AND UNIT WAS ADJUSTED. MONITOR AND ENSURE FOOD TEMPERATURES ARE MAINTAINED AT OR BELOW 41°F BEFORE STOCKING TCS ITEMS.

Comply By: 11/13/23

4-300 Equipment Numbers and Capacities

4-302.12B **** Priority 2 ****

MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.

THERMOMETER COULD NOT BE PRODUCED DURING INSPECTION. ENSURE THERMOMETER HAS A SMALL DIAMETER PROBE AND IS READILY ACCESSIBLE. ESTABLISHMENT WILL BE GETTING A NEW THERMOMETER.

Type: Full
Date: 11/13/23
Time: 12:31:44
Report: 1004231194
Horizon Care Llc

Food and Beverage Establishment Inspection Report

Page 2

Comply By: 11/13/23

4-300 Equipment Numbers and Capacities

4-302.13B ** Priority 2 **

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

NO IRREVERSIBLE TEMPERATURE INDICATORS FOR USE WITH THE HIGH TEMPERATURE SANITIZING DISH MACHINE. PROVIDE AND USE FREQUENTLY TO ENSURE A UTENSILS SURFACE TEMPERATURE OF 160*F OR ABOVE IS REACHED. *THERMOLABELS LEFT ON SITE FOR INSPECTION VERIFICATION.

Comply By: 11/13/23

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 HAND SOAP STOCKED AT KITCHEN HANDWASHING SINK. PROVIDE AND MAINTAIN AT ALL TIMES. SOAP WAS STOCKED FROM SUPPLY CLOSET DURING INSPECTION.

Comply By: 11/13/23

4-200 Equipment Design and Construction

4-201.11GMN

MN Rule 4626.0506G Discontinue serving TCS foods that are held for more than same-day service in an adult or child care center or boarding establishment or provide equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

STAFF STATED FOOD IS PREPARED DAY(S) AHEAD OF TIME FOR SERVICE. DISCONTINUE PREPARING FOOD FOR MORE THAN SAME-DAY SERVICE, OR PROVIDE COMMERCIAL, ANSI-ACCREDITED EQUIPMENT. DISCUSSED REQUIREMENT WITH HOUSE MANAGER AND OPERATOR ON SITE.

Comply By: 11/13/23

4-500 Equipment Maintenance and Operation

4-501.11AB

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

REFRIGERATOR WAS UNABLE TO MAINTAIN FOOD TEMPERATURES AT OR BELOW 41*F. REPAIR/ADJUST UNIT AND ENSURE FOOD TEMPERATURES ARE MAINTAINED AS REQUIRED. UNIT WAS ADJUSTED DURING INSPECTION.

Comply By: 11/13/23

Type: Full
Date: 11/13/23
Time: 12:31:44
Report: 1004231194
Horizon Care Llc

Food and Beverage Establishment Inspection Report

Page 3

8-500A Embargo/Condemnation

8-501.03MN

MN Rule 4626.1810 The following items are condemned and shall be removed from the establishment immediately:

FOOD ITEMS IN REFRIGERATOR WERE FOUND TO BE ABOVE 41°F. ALL PREPARED ITEMS (INCLUDING SOUPS, CASSEROLES, ETC) AS WELL AS TCS COMMERCIALY PROCESSED ITEMS (INCLUDING SALSA, COTTAGE CHEESE, SOUR CREAM, ETC) WERE DISCARDED DURING INSPECTION

Comply By: 11/13/23

Surface and Equipment Sanitizers

Utensil Surface Temp.: = at 160 Degrees Fahrenheit

Location: DISH MACHINE

Violation Issued: No

Food and Equipment Temperatures

Process/Item: CHICKEN NOODLE SOUP

Temperature: 49 Degrees Fahrenheit - Location: REFRIGERATOR

Violation Issued: Yes

Process/Item: SALSA

Temperature: 52 Degrees Fahrenheit - Location: REFRIGERATOR

Violation Issued: Yes

Process/Item: CUT LETTUCE

Temperature: 46 Degrees Fahrenheit - Location: REFRIGERATOR

Violation Issued: Yes

Process/Item: SOUP

Temperature: 50 Degrees Fahrenheit - Location: REFRIGERATOR

Violation Issued: Yes

Process/Item: AMBIENT TEMPERATURE

Temperature: 47 Degrees Fahrenheit - Location: REFRIGERATOR

Violation Issued: Yes

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

INSPECTION WAS CONDUCTED BY MOLLY DOUGHERTY (FPLS) IN CONJUNCTION WITH A HEALTH REGULATIONS DIVISION (HRD) SURVEY CONDUCTED BY TRACEY FEARON.

DISCUSSED:

-EMPLOYEE ILLNESS POLICY AND LOG

-HANDWASHING

-SANITIZER USE AND TEST KITS

-CLEANING/SANITIZING FOOD CONTACT SURFACES AND UTENSILS

-HIGH TEMPERATURE SANITIZING DISH MACHINE TEMPERATURE VERIFICATION

-DATE MARKING PROCEDURES

-SAME DAY SERVICE REQUIREMENT FOR RESIDENTIAL EQUIPMENT

Type: Full
Date: 11/13/23
Time: 12:31:44
Report: 1004231194
Horizon Care Llc

Food and Beverage Establishment Inspection Report

Page 4

- THERMOMETER USE AND CALIBRATION
- SERVING A HIGHLY SUSCEPTIBLE POPULATION (NO RAW/UNDERCOOKED ANIMAL FOODS, NO UNPASTEURIZED JUICE, MILK, ETC)
- VOMIT/FECAL INCIDENT CLEAN UP PROCEDURES
- FOOD SOURCE
- FOOD SERVICE PROCEDURES
- PEST CONTROL
- PHYSICAL FACILITIES AND MAINTENANCE

*REPORT WAS DISCUSSED WITH THE OPERATOR, ABDIRIZAK, THE HOUSE MANAGER, HUDA, AND WITH THE NURSE EVALUATOR, TRACEY.

*FLOORS ARE HARDWOOD, WALLS ARE PAINTED DRYWALL, CEILING IS "POPCORN" TEXTURE. COUNTERTOPS ARE STONE AND CABINETS ARE VARNISHED WOOD WITH HALLOW BASE. 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.

*KITCHEN HAS A 2-BASIN SINK. ONE BASIN IS DESIGNATED AS THE HANDWASHING SINK. THIS BASIN MAY ONLY BE USED FOR HANDWASHING PURPOSES.

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

INSPECTOR WILL RETURN FOR A FOLLOW-UP INSPECTION

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 1004231194 of 11/13/23.

Certified Food Protection Manager ABDIRIZAK A. JAMA

Certification Number: FM115593 Expires: 03/02/26

Inspection report reviewed with person in charge and emailed.

Signed: _____

ABDIRIZAK JAMA
OPERATOR

Signed: Molly Dougherty

Molly Dougherty
Public Health Sanitarian
Metro District Office
651-201-3978
molly.dougherty@state.mn.us