Protecting, Maintaining and Improving the Health of All Minnesotans

November 2, 2023

Licensee
Eden Prairie Senior Living, LLC
8480 Franlo Road
Eden Prairie, MN 55344

RE: Project Number(s) SL35049015

Dear Licensee:

On October 17, 2023, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the July 20, 2023, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Jonathan Hill, Supervisor
State Evaluation Team
Email: jonathan.hill@state.mn.us
Telephone: 651-201-3993 Fax: 1-866-890-9290

PMB

Electronically Delivered

September 22, 2023

Licensee
Eden Prairie Senior Living, LLC
8480 Franlo Road
Eden Prairie, MN 55344

RE: Project Number(s) SL35049015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 20, 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 - 1290 - 144g.60 Subdivision 1 - Background Studies Required = $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.

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.

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 MDH 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,

Jonathan Hill, Supervisor
State Evaluation Team
Email: jonathan.hill@state.mn.us
Telephone: 651-201-3993 Fax: 651-281-9796

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35049	A. BUILDING: _____ B. WING _____	07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDEN PRAIRIE SENIOR LIVING LLC	8480 FRANLO ROAD EDEN PRAIRIE, MN 55344

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL35049015-0 On July 18, 2023, through July 20, 2023 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 115 active residents; 35 receiving services under the Assisted Living with Dementia Care license. On July 20, 2023, at approximately 5:30 p.m. an immediate correction order was issued for tag 1290. The immediacy of the order was not removed at the time of exit on July 20, 2023.	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 with Dementia Care licensed providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480		

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0 480	Continued From page 1 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 included document titled, Food and Beverage Establishment Inspection Report dated July 18, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program.	0 800		

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0 800	Continued From page 2 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On a facility tour on July 19, 2023, from approximately 9:30 a.m. to 1:00 p.m. with the Vice President of Operations (VPO)-E and the Maintenance Staff (M)-M it was observed that the trash chute doors on the first, second and third floors did not shut and latch on their own. All trash chute doors should close and latch completely to maintain the fire resistance integrity of the trash chute system. VPO-E and M-M visually verified these deficient findings at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800		

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0 810	Continued From page 3	0 810		
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 a record review and interview, the	0 810		

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0 810	Continued From page 4 licensee failed to provide required resident training on fire safety and evacuation, and failed to conduct required evacuation drills. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A record review was conducted on July 20, 2023 and an interview was conducted on July 21, 2023, at approximately 1:00 p.m. with the Vice President of Operations (VPO)-E on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of the available documentation indicated that the licensee did not provide annual training to residents who can assist in their own evacuation on the proper actions to take in the event of a fire including movement, evacuation, or relocation as required by statute. During interview, VPO-E stated that the facility did not have documentation on offering resident training on the fire safety and evacuation plan. Record review of the available documentation indicated that the licensee did not conduct evacuation drills twice per year per shift and every other month as required by statute. Provided fire drill procedures policy indicated that	0 810		

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0 810	Continued From page 5 drills were conducted quarterly on various shifts. Licensee had documentation of drills completed on 3/24/23 and 6/23/23. During interview, VPO-E verified that there were no further documented drills for the facility and verified this deficient condition. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).	0 970		

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0 970	Continued From page 6 The findings include: On July 18, 2023, at 10:30 a.m., a copy of the facility's assisted living contract was requested. The assisted living contract used at the facility included a clause that indicated the resident would waive the facility's liability health, safety, or personal property of the resident. Page 13, section 18, noted, Personal Property: "resident agrees that Provider is not responsible for any loss or damage to Resident's personal property due to any reason or cause, including theft, other than Provider's own negligence. Resident further agrees that Provider is not responsible for damage to Resident's personal property due to fire, water, tornado or other acts of nature and events beyond Provider's control. On July 19, 2023, at approximately 10:30 a.m., regional vice president of operations (RVPO)-E stated all of the contracts were the same. RVPO-E added, the facility was working with their lawyer on the contract language, regarding page 13, section 18. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter	01290		

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01290	Continued From page 7 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed ensure a cleared NETStudy 2.0 background study (BGS) had been submitted and received for one of one employee (clinical nurse supervisor (CNS)-C); in addition, the facility lacked a system to check for BGS clearance. This had the potential, to affect all residents who reside at the facility. 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). This resulted in an immediate order for correction issued on July 20, 2023, at approximately 5:30 p.m. The findings include: On July 18, 2023, at 10:00 a.m., upon entrance,	01290		

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01290	Continued From page 8 the licensee's current census was requested. The licensed assisted living director (LALD)-A was unsure and stated she would provide the census. On July 18, 2023, at 10:25 a.m.,during the entrance conference the current census was again requested. The census was requested several times throughout the survey but was not received. CNS-C was hired on March 20, 2023, to provide supervision of staff and direct care services to the residents. On July 19, 2023, at 7:52 a.m., the surveyor observed unlicensed personnel (ULP)-H providing medication assistance to R4. ULP-H called CNS-C to update her regarding R4's pain status. CNS-C came to assess R4 and was observed taking R4's vital signs. ULP-H left the room prior to EMS (emergency services) arrival. CNS-C stayed with R4. CNS-C's employee record lacked evidence of a cleared BGS, affiliated with the licensee's current assisted living with dementia care license. On July 19, 2023, at 10:30 a.m., LALD-A stated the CNS-C was employed by the licensee beginning March 23, 2023. On July 20, 2023, at 7:55 a.m., LALD-A stated CNS-C did not have a completed background study (BGS). LALD-A stated the licensee submitted CNS-C's BGS on April 14, 2023, but was removed from the study because CNS-C had a current license in the state of Minnesota as a registered nurse (RN) since 2009. LALD-A stated	01290		

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01290	Continued From page 9 they were unaware it was required. Regional vice president of operation (RVPO)-E stated he removed several employees, including CNS-C from NETStudy 2.0 after attending an educational Webinar titled, Background Studies De-duplication dated November 29, 2022. On July 20, 2023, at 9:23 a.m., LALD-A stated she was not aware of the Minnesota Department of Health Guidance, Background Studies for HLB (Health Licensing Board) licensed Providers FAQ (Frequently Asked Questions) website. On July 20, 2023, at 10:45 a.m., the RVPO-E, also identified as the sensitive information person (SIP), stated per telephone conversation he attended a Net Study 2.0 webinar recently and understood when an employee had a license, they did not require a BGS. RVPO-E stated CNS-C was removed from the study. RVPO-E stated he was unaware this did not include licenses acquired prior to 2018. RVPO-E added once staff were removed (separated) from the roster, information regarding BGS clearance changes were no longer available to the facility. On July 20, 2023, at approximately 11:00 a.m., RVPO-E stated CNS-C's BGS was again submitted on July 19, 2023, and stated he did not look at Net Study 2.0 [website] since, because the BGS was "in process." LALD-A was observed to access the Net Study 2.0 webpage. RVPO-E stated CNS-C's BGS "triggered fingerprints again with current status as pending/in- process." LALD-A stated the report noted fingerprints were required and to be completed by August 2, 2023. CNS-C had a scheduled appointment today at 12:15 p.m. RVPO-E stated BGS would typically be done prior to completion of orientation, however the licensee did not have a process	01290		

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01290	Continued From page 10 because "they don't usually run BGS after fact." RVPO-E stated he considered this a "one -off situation." On July 20, 2023, at 11:30 a.m., the surveyor verified through Department of Human Services NETStudy 2.0 the following: - there was not a cleared background study in NETStudy 2.0 for CNS-C. On July 20, 2023, at 11:35 a.m., vice president of operations (VPO)-D and vice president of clinical services (VPCS)-B stated CNS-C was not currently supervised. On July 20, 2023, at 2:14 p.m., CNS-C stated she made the appointment to get her fingerprints processed on July 19, 2023, after learning her employee record did not include a completed background study. On July 20, 2023, at 2:23 p.m., LALD-A stated she receives emails regarding background study. LALD-A stated she was unaware of who overlooked the BGS process. On July 20, 2023, at 2:50 p.m., RVPO-E stated he oversaw 11 facilities and the LALD at each facility was responsible for "that" facility. RVPO-E said he and the LALD would normally receive an email when the BGS was "separated" from the facility. He explained that neither he, nor LALD-A received an email regarding CNS-C's BGS adding they would not receive an email if they facility removed the BGS themselves. On July 20, 2023, at 3:21 p.m., VPO-D stated when RVPO-E "pulled them up "(BGS for CNS-C) nothing was there on July 19, 2023. VPO- D stated another BGS was initiated by RVPO-E for	01290		

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01290	Continued From page 11 CNS-C. VPO-D produced a report from DHS dated April 29, 2023, that noted CNS-C's BGS was removed by task services on April 14, 2023, with a separation date April 29, 2023, because CNS-C's fingerprints were not completed. On July 20, 2023, at 3:31 p.m., CNS-C stated she did not receive an email notifying her fingerprints were needed. On July 20, 2023, at 3:32 p.m., VPO-D stated it was the LALD's responsibility to ensure all employees had a completed and cleared BGS prior to providing to residents. On July 20, 2023, at 3:35 p.m., VPO-D stated an email would not be sent because CNS-C did not complete the fingerprints for the BGS as required. On July 20, 2023, at 3:39 p.m., VPO-D asked CNS-C with surveyors present, if she received a notification from BGS and she denied receiving any email. Minnesota Department of Health guidance, Background Studies for HLB (Health Licensing Board) licensed Providers FAQ dated August 1, 2022, noted individuals who could be removed from NETStudy 2.0 rosters and/or not received a NETStudy 2.0 background study included individuals who: had a valid license from an HLB, had completed a background check under Minnesota Statues section 214.075, and not license applicants, owners, managerial officials, or controlling individuals of a home care provider, assisted living facility, or assisted living facility with dementia care. Minnesota Department of Health assumes providers historically have had methods for assuring their staff in positions requiring licensure maintained their licenses in	01290		

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01290	Continued From page 12 good standing. These processes should continue. The HLB updates the status of licenses daily, and that information is accessible on the HLB websites. Interested entities may also purchase automated daily updates of licensing data. Continuous Direct Supervision defined in NETStudy 2.0 System User Manual Updated July 7, 2023, page 7: Continuous, Direct Supervision - An individual is within sight or hearing of the program's supervising individual to the extent that the program's supervising individual is capable at all times of intervening to protect the health and safety of the persons served by the program. Direct Contact Services - Providing face-to-face care, training, supervision, counseling, consultation, or medication assistance to persons served by the entity. Supervision defined in, NETStudy 2.0 System User Manual Updated July 7, 2023, page 53: Supervision Status Study subjects must be under continuous, direct supervision until the study subject is determined eligible of until the entity is notified by DHS that the study subject may provide unsupervised services while the background study is being completed. The supervision status is shown in the "Supervision Required" column for convenience. However, programs are instructed to rely on background study notices for supervision status and other background study determination information. On July 20, 2023 at 4:10 p.m., the VPO-D stated all employees who have not cleared a BGS would be supervised at all times with eyes in them by a qualified licensed employee who had also cleared a BGS. VPO further stated qualified identified an employee to supervise only the areas that they were qualified to do meaning if it was a nursing	01290		

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01290	Continued From page 13 task only a nurse was able to supervise because they would both be educated and licensed in that field. VPO - D stated and maintenance person could not supervise a nurse. On July 20, 2023, at 4:27 p.m., the LALD-A stated the current census was 35 active with 115 total residents. VPO-D added a facility should know what their current census was. The licensee's Assisted Living Kari Koskinen Manager Background Check policy, dated August 1, 2021, indicated a background study would be completed on each prospective manager of the facility prior to being hired. The term: manager' includes any individual who had the means, within the scope of the individual's duties, to enter tenants' dwellings with a key. Documentation of a manager background check or a Minnesota Department of Human Services Background Study would be maintained in each employee's personnel file who had access to tenants' dwelling units using a key: -using MN DHS NETStudy online program, licensee would initiate a background study on all employees being considered for hire. -if hired prior to receiving the results of the background study, or the tentative background study results indicate more time was needed requiring supervision, new hires shall not be permitted to interact or provide services to clients of the licensee's except under the direct supervision (eyesight) of another quantified staff person. -once an approved background study has been received, staff may act independent with home care clients, assuming all other requirements have been met. -the licensee would initiate a new background study once per year on all staff, as part of the	01290		

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01290	Continued From page 14 annual performance review. -copies of completed background studies would be kept in individual personnel files. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01290		
01420 SS=D	144G.62 Subd. 2 Delegation of assisted living services (b) When the registered nurse or licensed health professional delegates tasks to unlicensed personnel, that person must ensure that prior to the delegation the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each resident and is able to demonstrate the ability to competently follow the procedures and perform the tasks. If the unlicensed personnel has not regularly performed the delegated assisted living task for a period of 24 consecutive months, the unlicensed personnel must demonstrate competency in the task to the registered nurse or appropriate licensed health professional. The registered nurse or licensed health professional must document instructions for the delegated tasks in the resident's record. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) provided written instructions in the resident's record for the delegated task provided by the unlicensed personnel (ULP) for one of four residents (R8) whose delegated task included application of a bunion (bony bump that forms on the joint at the base of the big toe) sleeve (used to ease the	01420		

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01420	Continued From page 15 rubbing that may occur when you wear shoes that have a narrow toe box, slips over your big toe and the ball of the foot, to cover the bunion). 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: R8's diagnoses included progressive vascular leukoencephalopathy (a progressive disorder that mainly affects the brain and spinal cord- central nervous system.) R8's service plan dated April 19, 2023, included AM (morning) cares: -resident needs to be ready no later than 9:30 a.m., so she can be escorted down to breakfast. Resident wears Depends-is incontinent at night. Put wet linens in laundry right away. Help resident with toileting. Gets dressed while on the toilet. Resident can sit in wheelchair at sink while brushing teeth and washing face. Make bed. R8's service plan, ULP task screen shot, effective date April 19, 2023, included the above information and "needs help putting shoes prior to sitting her up and getting her out of bed. Check feet for any new wounds". On July 19, 2023, at 8:15 a.m., the surveyor observed ULP-H assist R8 with morning cares. The surveyor observed a dressing (tan in color	01420		

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01420	Continued From page 16 approximately three (3) inches by three (3) inches) on the instep side and near the top of R8's right foot. R8 stated the nurse checked on the area yesterday. ULP-H placed a bunion sleeve over the top of R8's foot and then applied a sock over the bunion sleeve. On July 19, 2023, at 2:50 p.m., clinical nurse supervisor (CNS)-C stated she called R8's family regarding the "bunion" sleeve. CNS-C said she learned the bunion sleeve was not new, it had been a long-term use item. CNS-C stated there were no directions for staff regarding R8's bunion sleeve. On July 20, 2023, at 9:11 a.m., RN-B stated CNS-C told her you put it (bunion) sleeve on "like a sock." RN-B added, "I don't know what it is, but if staff is applying, direction should be given, and the nurse should know about it." The licensee's Medication & Treatment-Administration & Delegation policy dated August 1, 2021, noted a RN must specify, in writing, specific instructions for each resident and document those instructions in the resident's record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01420		
01440 SS=E	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a	01440		

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01440	Continued From page 17 registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure direct supervision of staff performing delegated tasks was provided within 30 calendar days after the date on which the individual began working for the licensee and first performed delegated tasks for two of three employees (unlicensed personnel (ULP)-H, ULP-G). 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	01440		

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01440	Continued From page 18 situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-H ULP-H was hired on March 10, 2023, to provide direct care services to residents at the assisted living with dementia facility. ULP-H's employee record included a 30-Day Staff Performance Review form dated April 10, 2023, which included the following categories: -Performance Factors (customer focus, communication, teamwork & attitude, productivity, safety, dependability) -Overall Performance Rating, scale -Areas For Development. ULP-H's record did not include documentation of a registered nurse (RN) supervising ULP-H performing a delegated task within 30 days of beginning work with the licensee. On July 20, 2023, at 8:51 a.m., licensed assisted living director (LALD)-A and RN-B stated ULP-H's 30-day supervision of performing a delegated task had not been completed as required. ULP-G ULP-G was hired on April 25, 2023, to provide direct care services to residents at the assisted living with dementia facility. ULP-G's employee record included a 30-Day Staff Performance Review form dated May 24, 2023, which included the following categories: -Performance Factors (customer focus, communication, teamwork & attitude, productivity, safety, dependability) -Overall Performance Rating, scale -Areas For Development.	01440		

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01440	Continued From page 19 On July 20, 2023, at 8:54 a.m., RN-B stated ULP-G's 30-day supervision of performing a delegated task had not been completed as required. RN-B stated the form used for ULP-G and ULP-H's 30-day supervision was missing a sentence and showed the surveyor a different form that should have been used. The licensee's Supervision of Staff-Delegated Services policy dated August 1, 2021, noted direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date of which the individual began working for the licensee and first performed the delegated tasks for resident and thereafter as needed based on performances. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of	01620		

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01620	Continued From page 20 services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive reassessment on day 14 (fourteen) for one of four residents (R5). 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: R5's diagnosis include cellulitis of left lower limb (skin infection) and began receiving assisted living services on May 13, 2022. R5's service plan dated May 13, 2022, included 14/90 day assessments, renewal orders, medication set-up, medication assist, AM (morning) cares, PM (evening) cares, escorts,	01620		

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01620	Continued From page 21 orientation to cares, shower assist, toileting assist, laundry service, and fall risk. R5's record included a pre-admission assessment dated February 16, 2022, an admission assessment dated May 13, 2022 and a 14/90 day assessment dated June 17, 2022; R5's 14-day assessment was completed 21 days late. On July 19, 2023, at 6:12 a.m., unlicensed personnel (ULP)-G was observed to assist R5 with morning cares, and apply compression (TED) to R5's lower legs. On July 19, 2023, at approximately 2:00 p.m., registered nurse (RN)-B stated R5's 14 day assessment was not completed as required. The licensee's Assessments, Reviews & Monitoring policy dated August 1, 2021, noted resident reassessment and monitoring would be completed no more than 14 calendar days after the initiation of services and by the RN. The policy lacked a procedure to identify how this would be ensured. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01640 SS=E	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the	01640		

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01640	Continued From page 22 facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure two of four residents (R4, R5) service plans were revised to include provided services. 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: R4 R4's diagnosis include chronic leg wounds,	01640		

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01640	Continued From page 23 chronic pain, and pneumonia due to inhalation of food and vomit. R4's service plan dated February 3, 2022, included assistant with AM (morning) cares: -is legally blind-able to tell you what she needs assistance with-her memory is good. Ambulates with walker independently. Is on oxygen at 2 liters (L) continuous- make sure her portable tank is full and assist her with putting it on and at 2 L. Is hard of hearing but doesn't like to wear her hearing aids. Incontinent of bladder-wears pull ups- assist her with good peri care, apply nystatin power for skin redness. Assist her with setting up grooming, assist if she requests. Wears full upper denture and lower partial. Assist her with choosing her clothes and assist her as she requests. Make her bed, take her garbage out. PM (evening) cares included: is on oxygen at 2 L continuous- make sure it is set at 2L. Assist her with choosing her pj's and assist her as she requests. On July 18, 2023, at 2:10 p.m., R4 was observed sitting in her recliner in her room . R4 had oxygen applied via a nasal cannula (a lightweight tube which on one end splits into two prongs which are placed in the nostrils to deliver supplemental oxygen) and an oxygen room concentrator set at 2 liters. R4 stated they had a recent fall which resulted in increaseed pain for which they received pain management (medication). On July 19, 2023, at 7:41 a.m., the surveyor observed ULP-H review R4's medication administration record (MAR) and ready R4's medication however R4 refused the medication. The surveyor observed R4's lower legs with a covering, wrap or sleeve. The surveyor observed R4 sitting in a recliner wearing a nasal cannula	01640		

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01640	Continued From page 24 and an oxygen room concentrator in R4's room was running, and the dial was set at 2 liters. R4's provider's order dated July 17, 2023, included: -wear brace when out of bed, OK to have Off when sitting, resting, hygiene as long as not at high risk of falls. Please limit your lifting to no more than ten pounds and avoid excessive bending, twisting, and turning at the lumbar spine. You should also avoid excessive jostling and jarring activities. On July 19, 2023, at 9:43 a.m., RN-B stated "we" (facility) has 24 hours to follow provider's orders, adding R4's service plan should have been updated to include R4's brace. R5 R5's diagnosis include cellulitis of left lower limb (skin infection), R5's service plan dated May 13, 2022, included assistant with AM cares: -alert and orientated. Very pleasant. Able to tell you her needs. Does have short-term memory loss so may repeat. Left sided paralysis from past stroke-able to transfer self and propel around in w/c (wheelchair) or scooter independently. Hearing good. Eyesight good. Has upper and lower dentures but does not wear. NO difficulty with chewing or swallowing. Incontinent of bladder wears pull-ups, assist with peri care. Assist with getting her dressed for the day. May her bed. Do her dishes of (sic) there is any to be done. Pick up apartment to prevent clutter/trip hazards, take out her garbage. Make sure she has her pendant on and remind her to push it if she needs assistance. PM cares included, assist with getting her	01640		

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01640	Continued From page 25 dressed for bed. On July 19, 2023, at 6:12 a.m., the surveyor observed unlicensed personnel (ULP)-G assist R5 with morning cares and apply compression (TEDs) to R5's lower legs. R5's provider's order dated September 20, 2022, included, "pt (patient) has compression stockings that need to put on, but she needs help putting them on. On July 19, 2023, at approximately 3:45 p.m., RN-B stated TEDs were not on R5's service plan as required. The licensee's Service Plan policy dated August 1, 2021, noted all residents receiving assisted living services would have a service plan in place. Service plans were based on the outcomes of initial and subsequent assessments, reassessments, monitoring, and individual reviews of the resident's needs and preferences. Service plans shall be revised, if needed, based on resident reassessments and monitoring. Service plans and any revisions or updates shall be entered into the resdient's record, including notice of change in fees when applicable. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01640		
01750 SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility	01750		

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01750	Continued From page 26 must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide specific resident instructions relating to the administration of medications for one of four residents (R4). 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: On July 19, 2023, at 7:41 a.m., the surveyor observed unlicensed personnel (ULP)-H review R4's medication administration record (MAR) and remove R4's dosage box (pre-set up seven-day medication planner), Advair Diskus 500-50 microgram (mcg) inhaler (difficulty breathing, wheezing, shortness of breath, coughing, and chest tightness), and Spriva Hand/Haler 18 mcg (relaxes airways and helps keep them open) from a locked medication cabinet.	01750		

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01750	Continued From page 27 R4's July 1, 2023, through July 18, 2023, MAR included: -Advair Diskus 500-50, 1 puff, two (2) times per day 8:00 a.m., 10:00 p.m. On July 19, 2023, at 9:56 a.m., registered nurse (RN)-B stated R4's MAR should include instructions for staff, to rinse mouth out after inhaling. The manufacturer's instructions for use of the Advair Diskus inhaler dated December 2021, indicated the user should rinse their mouth with water after use and spit the water out. Do not swallow the water. The licensee's Medication & Treatment-Administration & Delegation policy dated August 1, 2021, noted when administration of medications or treatment/therapy is delegated or assigned to unlicensed personnel, the facility would ensure that the registered nurse had: -specified, in writing, specific instructions for each resident and documented those instructions in the resident's records. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01760 SS=E	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who	01760		

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01760	Continued From page 28 administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered as prescribed for two of four residents' (R4, R5). Further, the licensee failed to ensure documentation as to why a medication was not given and failed to include documentation to include the effectiveness for as needed (PRN) medication administration for two of four residents (R4, R5). Also, the licensee failed to have medications available to administer as ordered for one of four residents (R4). In addition, the licensee failed to ensure the steps of the medication administration process was followed for one of three employees (unlicensed personnel (ULP)-G). 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).	01760		

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01760	Continued From page 29 The findings include: ADMINISTERED AS PRESCRIBED R4 R4's diagnosis included pneumonia (infection in lungs) due to inhalation of food and vomit. R4's service plan dated February 3, 2022, included medication assist daily. R4's Medication Assessment Face to Face form dated July 17, 2023, noted: -administration of medications -self-administers some medications- no. On July 19, 2023, at 7:41 a.m., the surveyor observed ULP-H review R4's medication administration record (MAR) and ready R4's medication however R4 refused the medication. R4 was complaining of pain. R4's prescriber orders dated July 17, 2023, included: -Lidocaine 4% Patch (pain), place 1 patch onto the skin every 24 hours to prevent lidocaine toxicity, patient should be patch free for 12 hours daily. R4's July 1, 2023, through July 18, 2023, medication administration record (MAR) included: -Lidocaine 5% ointment, three (3) times weekly, apply prior to wound dressing changes on ankle as directed. This is for wound care nurse to do. On July 19, 2023, at approximately 9:35 a.m., clinical nurse supervisor (CNS)-C stated she was told by R4's caseworker the only change was tramadol (moderate pain) was discontinued, and "oxy" (Oxycodone/severe) pain was added, and there were no other changes. CNS-C added they	01760		

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01760	Continued From page 30 do accept AVS (After Visit Summaries" if signed as orders. On July 19, 2023, at 9:41 a.m., registered nurse (RN)-B stated R4's provider's orders should have been clarified. R5 R5's diagnosis include cellulitis of left lower limb (skin infection). R5's service plan dated May 13, 2022, included medication assist daily. R5's Medication Assessment Face to Face form dated May 19, 2023, noted: -administration of medications -self-administers some medications- no. On July 19, 2023, at 7:32 a.m., the surveyor observed unlicensed personnel (ULP)-G administer R5's morning medication. R5's prescriber orders dated July 5, 2023, included: -nystatin powder 100,000 units/gram apply topically to erythema (abnormal redness due to capillary congestion/inflammation) underneath right abdominal skin fold twice a day. R5's July 5, 2023, through July 18, 2023, MAR included: -nystatin powder 100,000 small amount topically, two (2) times per day -25 of 27 opportunities nystatin powder was not administered as ordered. On July 19, 2023, at 1:42 p.m., RN-B stated R5's nystatin order was added after the MAR had been printed out for the month. "So, a separate page	01760		

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01760	Continued From page 31 was printed out," however the separate page was not attached to the other pages, and staff "missed" it. RN-B added it was a medication error. AS NEEDED OR DESIRED MEDICATION (PRN) R4 R4's record included PRN Medication tracking sheets: -Senokot, one (1) tab, two (2) times a day for constipation -Lidocaine Patch, on for 12 hours and off for 12 hours, to lower back -Oxycodone 5 milligrams (mg) (severe) pain, take 1/2 to 1 tablet by mouth every six (6) hours. Senokot -0 of 3 opportunities Senokot's effectiveness was noted on the PRN tracking form. Lidocaine Patch -0 of 3 opportunities Lidocaine Patch's effectiveness was noted on the PRN tracking form. Oxycodone -1 of 2 opportunities Oxycodone's effectiveness was noted on the PRN tracking form. R5 R5's record included PRN Medication tracking sheets: -Imodium 2 mg, one (1) tablet by mouth every six (6) hours for diarrhea, no more than four (4) tabs in 24 hours. -3 of 14 opportunities Imodium's effectiveness was noted on the PRN tracking form. On July 19, 2023, at 9:42 a.m., registered nurse (RN)-B stated staff are to check in half an hour to	01760		

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01760	Continued From page 32 one hour later for PRN effectiveness. RN-B said R4 and R5's records did not include monitoring of effectiveness for PRN medications administrated. MEDICATION SUPPLY R4 R4's service plan dated February 3, 2022, noted any client receiving a medication package: -staff nurse was responsible for monitoring supplies and ensuring refills are maintained by faxing or calling the refill prescription or request. R4's prescriber order dated July 17, 2023, included: -polyethylene glycol-propylene glycol (also known as Systane Ultra/ dry eyes) 0.4- 0.3 % solution, place two (2) drops into both eyes every hour as needed. On July 19, 2023, at approximately 10:35 a.m., RN-B stated Systane eye drops were not in R4's medication cabinet, adding they should have been ordered and available for R4's use. RN-B said she would look to see if the drops had been ordered, and if not, she would see they were ordered. RN-B stated, it is a signed order, we either need to have the medication or get new orders. MEDICATION ADMINISTRATION PROCESS ULP-G On July 19, 2023, at 6:12 a.m., the surveyor observed ULP-G assist R5 with morning cares, apply compression stockings (TEDs) and wash R5's clothes and make R5's bed. ULP-G then took R5 to the dining area. ULP-G went back to R5's room and placed the medication from a pre-set medication seven-day planner into a medication cup: -cranberry 500 mg capsule (UTI/ urinary tract	01760		

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01760	Continued From page 33 infection prevention) -vitamin B12 1000 micrograms (mcg), (supplement) -vitamin C 500 mg, (UTI prevention) -vitamin D 50 mcg (2000 units) (deficiency) -acetaminophen 500 mg, two (2) tablets. and documented the medications were given. ULP-G also documented: -Calmoseptine 0.44-20.6 % (moisture) as given, 8:00 a.m., 12 p.m., 8:00 p.m. Directly after the above observation ULP-G stated R5 does not use "Aqua lotion" pointing to a product in the bathroom, adding only if R5 has diarrhea. ULP-G said she was trained to document on the product, "if it was available." The surveyor observed ULP-G administer R5's medications. On July 19, 2023, at approximately 10:30 a.m., RN-B stated staff should document after giving and doing, and not to document what was not done, adding staff are trained to circle and initial when items are refused. RN-B said she was "going to say" ULP-G was in a hurry when she signed off items at different times however, RN-B added, ULP-G assisted with the R 5's shower. RN-B said she did not know where ULP-G "got that" (to document if available). The licensee's Medication & Treatment Orders-Implementing policy dated August 1, 2021, noted upon receipt of a medication and/ or treatment order, whether new or change of an order from an authorized prescriber, a licensed nurse must take action to implement the order within 24 hours. The licensee's Medication & Treatment Record-Documentation & Refusal policy dated	01760		

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01760	Continued From page 34 August 1, 2021, noted if medication and or treatment/therapy assistance and/or administration was not completed as prescribed, documentation must include the reason why it was not completed and any follow up procedures that were provided. Documentation of medication/ treatment/therapy reminders, medication/treatment/therapy assistance or medication/treatment/therapy administration would be completed by the person who performed the task immediately after the medication assistance/administration was completed. To indicate the medication/ treatment was refused, circle your initials and write a capital R in the same box on the MAR or TAR (treatment administration record). No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01880 SS=F	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 the medications were stored according to manufacturer's instructions by maintaining acceptable medication refrigerator temperatures. In addition, the licensee failed to ensure medication was secured in a locked area for two	01880		

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01880	Continued From page 35 of four residents (R5, R4). 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: MEDICATION STORED ACCORDING TO MANUFACTURER'S RECOMMENDATIONS On July 18, 2023, at 11:42 a.m., the surveyor and clinical nurse supervisor (CNS)-C reviewed the contents of the medication refrigerator in the nursing office. CNS-C stated the current temperature of the medication refrigerator was 35-degrees Fahrenheit (F). CNS-C said the temperature of the refrigerator should be 35 degrees F to 38 degrees F. CNS-C observed the medication refrigerator and confirmed the following contents: -40 bisacodyl suppositories 10 milligrams (mg) -3 unopened Lantus 100 units/milliliter (ml) (long-acting) insulin pens -2 bottles of lorazepam (anxiety) 2 milligrams (mg)/ml -22 syringes of lorazepam 2 mg/ml, 0.25 ml. -3 bags of COVID tests (57 syringes) -two red top testing tubes. Directly following the above observation registered nurse (RN)-B stated she was not sure what the red topped test tubes were for, they did not need to be in the refrigerator, adding she would just get rid of them.	01880		

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01880	Continued From page 36 On July 18, 2023, at 12:05 p.m., CNS-C called licensed practical nurse (LPN)-M to inquire about the medication refrigerator's temperature log. On July 18, 2023, at 12:11 p.m., LPN-M stated the refrigerator was supposed to be checked every week. LPN-M said, to be honest, it was not checked the prior week, adding, "it was crazy." LPN-M stated there were no temperature logs for the medication refrigerator, adding temperature logs were in resident's rooms when resident's medications required refrigeration. The manufacturer's instructions for bisacodyl suppositories dated November 21, 2022, noted store at room temperature 59 to 86 degrees F. The manufacturer's instructions for Lantus insulin dated June 12, 2023, noted always store unopened Lantus pens in the refrigerator 36 degrees F to 46 degrees F. The manufacturer's instructions for lorazepam (Ativan) dated 2022, noted store between 36 to 46 degrees F. The manufacturer's instructions for COVID tests dated September 23, 2022, noted store between 35 and 86-degrees F. SECURE MEDICATION STORAGE R5 On July 18, 2023, at 11:03 a.m., the surveyor observed a container of Biofreeze (muscle pain relief), two (2) partial containers of nystatin powder (yeast), and an almost empty tube of calmoseptine ointment 0.44-20.6% (to treat and prevent minor skin irritations) in R5's bathroom.	01880		

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01880	Continued From page 37 On July 19, 2023, at 7:32 a.m., the surveyor observed unlicensed personnel (ULP)-G administer R5's morning medication. R5's provider order dated April 11, 2023, included: -Biofreeze 4% gel, thin layer topical, apply to left knee and right elbow as needed for pain, okay for resident to self-administer -nystatin 100,000 unit/gram powder, small amount- topical, for skin redness. R5's provider order dated July 5, 2023, included "nystatin powder 100,000 units/gram apply topically to erythema (abnormal redness due to capillary congestion/inflammation) underneath right abdominal skin fold bid," (twice a day). R5's Medication Assessment Face to Face form dated May 19, 2023, noted: -administration of medications -self-administers some medications: no R5's service plan dated May 13, 2022, noted any client receiving a medication package: -medication managed by the home care provider shall be stored to prevent diversion of medications by clients or others who may have access to the medications. Diversion means the misuse, theft, or illegal or improper dispositions of medications -medications would be stored in a locked medication box in client's private living space. R5's July 1, 2023, through July 20, 2023, medication administration record (MAR) included calmoseptine 0.44-20.6% ointment, thin layer, three (3) times per day, to peri-area and bottom, can apply after toileting.	01880		

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01880	Continued From page 38 On July 18, 2023, at 3:26 p.m., registered nurse (RN)-B stated R5 was "ok" to have Bio-freeze in her room, nystatin, and calmoseptine, adding R5 could self-apply, however medication should be "locked up." R4 On July 19, 2023, at 7:41 a.m., the surveyor observed ULP-H review R4's MAR and ready R4's morning medication, however R4 refused the medication. Directly following the above observation, the surveyor observed a new container of Tums on R4's counter, a tube of Aquaphor (protects and soothes extremely dry skin), approximately half a container of Nystop (fungal skin infections), and container of Nyamyc (yeast) with a very small amount of powder in R4's bathroom. In addition, there was an open container of Tums on a side table near R4's recliner, an opened container of Bra Bearies with CBD Strawberry Gummies for "chilling", and a tube of antibiotic ointment and pain relief "one squeeze". R4's provider's orders dated July 17, 2023, included: -Tums, take one (1) chew tablet by mouth two (2) times daily as needed PRN) for heartburn -nystatin 100000 unit/gram external powder, apply topically two (2) times daily PRN for other. R4's Medication Assessment Face to Face form dated July 17, 2023, noted: -administration of medications -self-administers some medications: no R4's service plan dated February 3, 2022, noted any client receiving a medication package: -medication managed by the home care provider	01880		

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01880	Continued From page 39 shall be stored to prevent diversion of medications by clients or others who may have access to the medications. Diversion means the misuse, theft, or illegal or improper dispositions of medications -medications would be stored in a locked medication box in client's private living space. R4's July 1, 2023, through July 13, 2023, MAR included Aquaphor (moisture) ointment, small amount topical, daily able to self-administer. On July 19, 2023, at 1:46 p.m., RN-B stated staff should be administrating R4's medications and they should be locked up, all but the Tums. RN-B added R4's medication assessments and R4's MAR (PRN sheet) did not match. The licensee's Medication Storage policy dated August 1, 2021, noted medications would be stored consistent with each resident's medication management plan and service plan. Medications would be stored consistent with manufacturer's recommendations (refrigerated, room temperature, or frozen. In addition, medications managed by the licensee would be stored to prevent diversion of medications by residents or others who have access to the medication. Medications would be stored in a locked medication box/ cabinet in client's private living space. Medication managed outside of a resident's private "living space' must be in securely locked and substantially constructed compartments and permit only authorized personnel to have access. This may be a medication room, medication cart, or similar setup. No further information was provided.	01880		

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01880	Continued From page 40 TIME PERIOD FOR CORRECTION: Seven (7) days	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 legible information including the opened-on date for time sensitive medication for R4, and other residents using eye drops and inhalers. 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: TIME SENSITIVE MEDICATIONS On July 18, 2023, at 12:16 p.m., during an interview with licensed practical nurse (LPN)-M she stated she was not sure if eye drops or	01890		

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01890	Continued From page 41 inhalers used at the facility were dated. On July 18, 2023, at 12:18 p.m., registered nurse (RN)-B stated the expectation was eye drops, insulin, and inhalers should be dated. R4's opened Advair Diskus (difficulty breathing, wheezing, shortness of breath, coughing, and chest tightness caused by asthma) 500 micrograms (mcg)/50 milligrams (mg) inhaler, lacked a date the inhaler was removed from the foil package and when the inhaler would expire. On July 19, 2023, at 9:31 a.m., clinical nurse supervisor (CNS)-C called LPN-M in regard to eye drops and inhaler, inquiring if they were dated, when opened, and when they would expire. LPN-M stated she looked, eye drops and inhalers used at the facility were not dated. PRESCRIPTION LABEL R4 On July 19, 2023, at 7:41 a.m., the surveyor observed unlicensed personnel (ULP)-H review R4's medication administration record (MAR) and removed Advair Diskus 500-50 mcg/mg inhaler. The surveyor did not observe R4's name on the Advair inhaler, or a box the Advair inhaler had been in, in R4's locked medication cabinet. Directly after the above observation ULP-H stated the box or any prescription information for R4's Advair Diskus was not in R4's locked medication cabinet. On July 19, 2023, at 2:42 p.m., LPN-M stated R4's Advair inhaler was in a bag and the bag had contained the prescription information, adding if it was not there, "someone threw it out".	01890		

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01890	Continued From page 42 The licensee's Medication Storage policy dated August 1, 2023, noted medications would be stored consistent with manufacturer's recommendations. The licensee's Medications-Prescribed, Not Prescribed & OTC (over the counter) policy dated August 1, 2021, noted the facility must verify that the medication is up to date and stored as appropriate. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01950 SS=F	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and	01950		

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01950	Continued From page 43 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) prepared in writing specific instructions for each resident and documented those instructions for three of three residents (R4, R5, R6). 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: R4 R4's diagnoses included chronic leg wounds, chronic pain, and pneumonia (lung infection) due to inhalation of food and vomit. R4's service plan dated February 3, 2022, included assistant with AM (morning) cares: -is legally blind-able to tell you what she needs assistance with-her memory is good. Ambulates with walker independently. Is on oxygen at 2 liters (L) continuous- make sure her portable tank is full and assist her with putting it on and at 2 L. Is hard of hearing but don't like to wear her hearing aids. Incontinent of bladder-wears pull ups- assist her with good peri care, apply nystatin power for skin redness. Assist her with setting up grooming, assist if she requests. Wears full upper denture and lower partial. Assist her with choosing her clothes and assist her as she requests. Make her	01950		

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01950	Continued From page 44 bed, take her garbage out. PM (evening) cares included: is on oxygen at 2 L continuous- make sure it is set at 2L. Assist her with choosing her pj's and assist her as she requests. R4's service plan, task screenshot effective day December 22, 2022, included: -remove ace wraps (stretchable cloth/ compression bandage) from feet and ankle. On July 19, 2023, at 7:41 a.m., the surveyor observed unlicensed personnel (ULP)-H review R4's medication administration record (MAR) and ready R4's medication however R4 refused the medication. The surveyor observed R4's lower legs with a covering, wrap or sleeve. The surveyor observed R4 sitting in a recliner wearing a nasal cannula (a lightweight tube which on one end splits into two prongs which are placed in the nostrils to deliver supplemental oxygen) and an oxygen room concentrator in R4's room was running, and the dial was set at 2 liters. R4's provider's order dated July 17, 2023, included: -wear brace when out of bed, OK to have Off when sitting, resting, hygiene as long as not at high risk of falls. Please limit your lifting to no more than ten pounds and avoid excessive bending, twisting and turning at the lumbar spine. You should also avoid excessive jostling and jarring activities -oxygen, continuous 4 L, nasal cannula -use Vashe (wound cleanser) to saturate a roll of Kerlix gauze. Wrap patient's lower leg with the moist gauze. Allow to soak for ten minutes, removed gauze and allow leg to dry, swab peri-wound with no-string barrier and allow to dry, cover distal wound with a Optifoam border, initial	01950		

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01950	Continued From page 45 and date, apply a small piece of non-adherent gauze to would and cover with Optifoam border. On July 19, 2023, at 9:43 a.m., RN-B stated "we" (facility) has 24 hours to follow provider's orders, adding R4's record should have been updated to include specific instructions for R4's brace, to be worn when up walking. On July 19, 2023, at 9:57 a.m., RN-B stated R4's record did not include specific instructions for R4's oxygen administration. On July 19, 2023, at 9:59 a.m., RN-B stated R4's record did not include specific instructions for R4's Ace wraps. RN-B added homecare would be doing R4's wound care. R5 R5's diagnosis included cellulitis of left lower limb (skin infection). R5's service plan dated May 13, 2022, included assistant with AM cares: -alert and orientated. Very pleasant. Able to tell you her needs. Does have short-term memory loss so may repeat. Left sided paralysis from past stroke-able to transfer self and propel around in w/c (wheelchair) or scooter independently. Hearing good. Eyesight good. Has upper and lower dentures but does not wear. NO difficulty with chewing or swallowing. Incontinent of bladder wears pull-ups, assist with peri care. Assist with getting her dressed for the day. Make her bed. Do her dishes of (sic) there is any to be done. Pick up apartment to prevent clutter/trip hazards, take out her garbage. Make sure she has her pendant on and remind her to push it if she needs assistance. PM cares included, assist with getting her	01950		

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01950	Continued From page 46 dressed for bed. R5's provider's order dated September 20, 2022, included, "pt (patient) has compression stockings that need to be put on but she needs help putting them on." On July 19, 2023, at 6:12 a.m., the surveyor observed ULP-G assist R5 with morning cares and apply compression (TEDs) to R5's lower legs. On July 19, 2023, at 1:18 p.m., RN-B stated R5's record did not include specific instructions for R5's TEDs. R6 R6's diagnosis included diabetes, type 2. R6's service plan dated June 3, 2022, included: medication assist, assist with checking her blood sugar every day. R6's service plan, task screenshot effective day June 22, 2023, included blood sugar check, overnight aide needs to check blood sugar every morning prior to breakfast. R6's provider order dated June 6, 2023, included: blood glucose monitoring, finger prick, before meals and at bedtime 7 a.m. (morning), 12 p.m. (afternoon), 4 PM, 8 PM indicated for type 2 diabetes. On July 19, 2023, the surveyor observed ULP-H take R6's blood sugar using correct technique. R6's blood sugar reading was 196. The surveyor asked ULP-H about directions for blood sugar monitoring. ULP-H checked the phone she carried which was used for services check off,	01950		

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01950	Continued From page 47 there were no instruction on the phone for R6's blood sugars reading when and what to report to nurse. ULP-H checked R6's medication administration record (MAR) and stated there were no instruction there for R6's blood sugar checks. On July 19, 2023, at 1:47 p.m., RN-B stated "normally" put call nurse when less than 70 or greater than 250 for blood sugar monitoring. RN-B said R6's record did not include specific instructions for R6's blood sugar monitoring. The licensee's Support Stockings/TED Hose policy dated August 1, 2021, noted rinse the stockings with water and hang to dry each night, and notify RN of any abnormal sores, bruising, or skin rashes. The licensee's Competency Training Evaluations policy dated August 1, 2021, noted when tasks that are frequent delegated to ULPs to include TED stockings, oxygen administration, Ace bandage application, leg braces, etc. the RN or licensed health professional must document instructions for the delegated tasks in the client's record. The licensee's Medication & Treatment-Administration & Delegation policy dated August 1, 2021, noted when administration of medications or treatment/therapy is delegated or assigned to unlicensed personnel, the facility would ensure that the registered nurse had: -specified, in writing, specific instructions for each resident and documented those instructions in the resident's records. No further information was provided.	01950		

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01950	Continued From page 48 TIME PERIOD FOR CORRECTION: Seven (7) days	01950		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure treatments or therapies were administered as prescribed for one of four residents (R4). 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: R4's diagnosis included pneumonia (lung infection) due to inhalation of food and vomit.	01960		

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01960	Continued From page 49 R4's service plan dated February 3, 2022, included assistant with AM (morning) cares: Is on oxygen at two (2) liters (L) continuous- make sure her portable tank is full and assist her with putting it on and at two (2) L. PM (evening) cares included: is on oxygen at two (2) L continuous- make sure it is set at two (2) L. On July 19, 2023, at 7:41 a.m., the surveyor observed unlicensed personnel (ULP)-H review R4's medication administration record (MAR) and ready R4's morning medication however R4 refused the medication. The surveyor observed R4 sitting in a recliner wearing a nasal cannula (a lightweight tube which on one (1) end splits into two (2) prongs which are placed in the nostrils to deliver supplemental oxygen) and an oxygen room concentrator in R4's room was running and the dial was set at two (2) liters. Directly after observing the above observation clinical nurse supervisor (CNS)-C stated R4 receive's two (2) L of oxygen, "always has two (2) L" of oxygen. R4's provider's order dated July 17, 2023, included: -oxygen, continuous 4 L, nasal cannula. On July 19, 2023, at approximately 9:35 a.m., CNS-C stated she was told by R4's caseworker the only change was tramadol (moderate pain) was discontinued, and "oxy" (Oxycodone/ severe) pain was added, no other changes. CNS-C added they do take AVS (After Visit Summaries) if signed, as orders. On July 19, 2023, at 9:41 a.m., registered nurse (RN)-B stated R4's provider's orders should have	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35049	A. BUILDING: _____ B. WING _____	07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDEN PRAIRIE SENIOR LIVING LLC	8480 FRANLO ROAD EDEN PRAIRIE, MN 55344

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01960	Continued From page 50 been clarified. The licensee's Medication & Treatment Orders-Implementing policy dated August 1, 2021, noted, upon receipt of a medication and/or treatment order, whether new or change of an order from an authorized prescriber, a licensed nurse must take action to implement the order within 24 hours. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		
02070 SS=F	144G.81 Subd. 4 Awake staff requirement An assisted living facility with dementia care providing services in a secured dementia care unit must have an awake person who is physically present in the secured dementia care unit 24 hours per day, seven days per week, who is responsible for responding to the requests of residents for assistance with health and safety needs, and who meets the requirements of section 144G.41, subdivision 1, clause (12). This MN Requirement is not met as evidenced by: Based on observation and interview the licensee failed to ensure one or more persons were physically present and available 24 hours a day, seven days a week, who were responsible for responding to requests for assistance with health and safety needs of residents in one of two secure dementia care units. This had the potential to affect all 6 residents residing in the second-floor memory care unit.	02070		

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	35049	A. BUILDING: _____ B. WING _____	07/20/2023

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02070	Continued From page 51 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference of July 18, 2023, at 10:30 a.m., the licensed assisted living director (LALD-A) stated staff was available at all times for resident care and assistance. LALD-A further explained the licensee's memory care units staffed two unlicensed personnel on the night (NOC) shift. The physical layout of the facility included secured units on the first and second floor, both required key-pad access to enter and exit. On July 19, 2023, at 5:31 a.m., the surveyor observed the secured unit on the second floor to be darkened and a person sitting in a chair positioned near a window, against the wall, in the dining area of the open common's area. The person was wearing a jacket with his right hand up over his head. The jacket covered his face. The surveyor heard the person snoring. On July 19, 2023, at 5:35 a.m., the person in the chair woke up to the surveyor's voice, while video recording him. The person stated his name and position as unlicensed personnel (ULP)-F adding he was the only staff working in the second-floor secured unit. ULP-F stated "no, no, no, was not sleeping." He added "I do like this; I do like this"	02070		

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02070	Continued From page 52 as he demonstrated putting his right hand up and placed it on his forehead while his jacket covered his face. Directly following the above observation and conversation between ULP-F and the surveyor ULP-F asked the surveyor to delete the video recording of him sleeping/snoring. ULP-F stated he was not to leave the secure unit or sleep. On July 19, 2023, at 6:03 a.m., registered nurse (RN)-B stated ULPs can't sleep on the unit. On July 19, 2023, at 1:56 p.m., RN-B stated they have camera's by exits to watch resident's not staff. RN-B added hourly rounding is done and it is the expectation that "you don't sleep." RN-B added no one watched me, "that I was not sleeping, when I worked nights". The licensee's Acceptance of Residents Policy dated August 1, 2021, noted the licensee would only accept a resident if the facility had staff, sufficient in qualifications, competency, and numbers, to adequately provide the services agreed to in each resident's Assisted Living Contract and are within the scope of the facilities disclosed services. The licensee's Uniform Disclosure of Assisted Living Services and Amenities dated May 16, 2021, noted unlicensed staff were in the building and available to respond to resident requests 24/7. No further information provided. TIME PERIOD FOR CORRECTION: Two (2) days	02070		

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02310	Continued From page 53	02310		
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 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 provide care and services according to acceptable health care, medical, or nursing standards for storage of cleaning products. In addition, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for storage of oxygen for two oxygen tanks. Further, the licensee failed to ensure the care and services were provided according to acceptable health care, medical, or nursing standards for one of two residents (R4) with an assistive device of hospital-style bed rails and one of two residents (R5) with an assistive device (consumer bedrail). 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:	02310		

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02310	Continued From page 54 CLEANING SUPPLIES On July 18, 2023, at 10:22 a.m., the surveyor toured the secured unit on the first floor of the facility. There was an opened door in the dining/ common's area, with a sign on it that noted, this door must be shut when you leave kitchenette. The surveyor observed a staff member leaving the area to assist a resident. The room contained an open bottle of Clorox Disinfecting Bio Stain & Odor Remover, and an open bottle of Germicidal Foaming Cleaner on a shelf above the sink area. On July 19, 2023, at 5:41 a.m., the surveyor observed the door to the kitchenette in the first-floor secured unit open. There was one (1) resident sitting in a chair in the open common's area. The surveyor did not observe a staff member in the common's area. On July 19, 2023, at 5:45 a.m., unlicensed personnel (ULP)-L entered the common's area. ULP-L stated the door was not supposed to be open to the kitchen. On July 19, 2023, at 6:04 a.m., registered nurse (RN)-B stated the door to the kitchenette was to be closed, adding there is a sign on the door to keep it closed. RN-B said there were chemicals in the room. The Safety Data Sheet for Clorox Disinfecting Bio Stain and Odor Remover dated July 7, 2017, noted: -inhalation: remove to fresh air. If symptoms persist, call a physician -eye contact: rinse eyes. Get medical attention if irritation develops and persists -skin contact: wash skin with soap and water. Get medical attention if irritation develops and persists.	02310		

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02310	Continued From page 55 -ingestion: clean mouth with water and rinse afterwards with plenty of water. Never give anything by mouth to an unconscious person. Do NOT induce vomiting. Call a physician. The Safety Data Sheet for Germicidal Foaming Cleaner dated December 31, 2014, noted: -WARNING, causes serious eye irritation -wash hands, face and any skin contact thoroughly after handling -wear eye protection/face protection -if in eyes, rinse cautiously with water for several minutes. Remove contact lenses, if present and easy to do. Continue rinsing. If eye irritation persists; get medication advice/attentions. First-Aid Measures: -Ingestion: call a poison control center or doctor immediately for treatment advice. Have person sip a glass of water if able to swallow. Do not induce vomiting unless told to do so by the poison control center or doctor. Do not give anything by mouth to a person who is unconscious or convulsing. If vomiting occurs, keep head below hips to reduce risk of aspiration. Storage: keep out of reach of children. Do not contaminate water, food or feed by storage and disposal. Store in tightly closed, original container in a cool, dry area. The Minnesota Bill of Rights dated November 8, 2022, noted residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. The licensee's Housekeeping policy dated August 1, 2021, noted, Staff members would be trained	02310		

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02310	Continued From page 56 in the following: -all housekeeping procedures -use, labeling, and storage of chemicals -fire and safety hazards and health concerns to be reported -safety precautions -tenant preferences. OXYGEN STORAGE The licensee's Oxygen policy dated August 1, 2021, noted oxygen cylinders and vessels must remain upright at all times. Never tip an oxygen cylinder or vessel on its side or try to roll it to a new location. Minnesota Department of Health guidance, Oxygen Cylinder Storage Requirements, dated April 16, 2020, indicated oxygen cylinders must be secured (chains or racks) to prevent them from falling over. ASSISTIVE DEVICES Hospital Side Rails R4 R4's diagnosis include chronic leg wounds, chronic pain, and pneumonia due to inhalation of food and vomit. On July 19, 2023, at 7:41 a.m., the surveyor observed ULP-H review R4's medication administration record (MAR) and ready R4's medication however R4 refused the medication. The surveyor observed R4's lower legs with a covering, wrap or sleeve. The surveyor observed R4 sitting in a recliner wearing a nasal cannula (a lightweight tube which on one end splits into two prongs which are placed in the nostrils to deliver	02310		

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02310	Continued From page 57 supplemental oxygen). R4 had a hospital type of bed in her room with upper side rails in the raised position. ULP-H stated R4 used the bedrail's to assist with transfers and bed mobility. Consumer Bed Rails R5 R5's diagnosis include cellulitis of left lower limb (skin infection), On July 19, 2023, at 6:12 a.m., the surveyor observed unlicensed personnel (ULP)-G assist R5 with morning cares, and apply compression (TEDs) to R5's lower legs. R 5' s' bed had a halo type (circular) of siderail attached to her bed. R5 stated she used the halo device to sit up when in 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 4 and 3/4 inches. The 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". No further information was provided.	02310		

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02310	Continued From page 58 TIME PERIOD FOR CORRECTION: Two (2) days	02310		

Minnesota Department of Health
Food, Pools, & Lodging Services
P.O. Box 64975
Saint Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *07/18/23*
Time: 13:00:00
Report: 1005231128

Food and Beverage Establishment Inspection Report

Location:
Eden Prairie Senior Living Llc
8480 Franlo Road
Eden Prairie, MN55344
Hennepin County, 27

Establishment Info:
ID #: 0038110
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6516001821
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.

3-500B 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.

TCS FOODS IN THE MAIN LINE PREP COOLER WERE 43-44 DEGREES F. MANAGER WILL HAVE COOLER ADJUSTED, OR SERVICED IF NEEDED.

Comply By: 07/18/23

Surface and Equipment Sanitizers

Quaternary Ammonia: = 200PPM at Degrees Fahrenheit
Location: WIPING CLOTH BUCKET
Violation Issued: No

Quaternary Ammonia: = 200PPM at Degrees Fahrenheit
Location: 3-COMP DISPENSER
Violation Issued: No

Utensil Surface Temp.: = at 160 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Hot Hold/SALMON
Temperature: 154 Degrees Fahrenheit - Location: STEAM TABLE
Violation Issued: No

Process/Item: Hot Hold/PEAS
Temperature: 184 Degrees Fahrenheit - Location: STAEM TABLE
Violation Issued: No

Process/Item: Hot Hold/SOUP
Temperature: 158 Degrees Fahrenheit - Location: SOUP WARMER
Violation Issued: No

Process/Item: Cold Hold/SOUR CREAM
Temperature: 43 Degrees Fahrenheit - Location: MAIN LINE PREP COOLER
Violation Issued: Yes

Process/Item: Cold Hold/HALF AND HALF
Temperature: 44 Degrees Fahrenheit - Location: MAIN LINE PREP COOLER
Violation Issued: Yes

Process/Item: Cold Hold/SALMON
Temperature: 39 Degrees Fahrenheit - Location: MAIN LINE PREP COOLER
Violation Issued: No

Process/Item: Cold Hold/MILK
Temperature: 40 Degrees Fahrenheit - Location: NORLAKE 2-DOOR COOLER
Violation Issued: No

Process/Item: Cold Hold/MUSHROOM SAUCE
Temperature: 37 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Hold/MEATLOAF
Temperature: 37 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Hold/CANTALOUPE
Temperature: 38 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Hold/MILK
Temperature: 40 Degrees Fahrenheit - Location: 1ST FLOOR MEMORY CARE KITCHENETTE
Violation Issued: No

Process/Item: Cold Hold/MILK
Temperature: 40 Degrees Fahrenheit - Location: 2ND FLOOR MEMORY CARE KITCHENETTE
Violation Issued: No

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

INSPECTION COMPLETED WITH MANAGER AND EMAILED TO HRD NURSE EVALUATOR MARY BRUESS.

DISCUSSED ORDER ON REPORT AS WELL AS COOLING, DATE-MARKING, STORAGE OF RAW MEATS, AND EMPLOYEE ILLNESS.

REVIEWED SYMPTOMS OF FOODBORNE ILLNESSES AND THE REQUIREMENT TO

Type: Full
Date: *07/18/23*
Time: 13:00:00
Report: 1005231128
Eden Prairie Senior Living Llc

Food and Beverage Establishment Inspection Report

MAINTAIN AN EMPLOYEE ILLNESS LOG OF THOSE INSTANCES WHEN EMPLOYEES ARE ILL WITH VOMITING OR DIARRHEA "AND" IMMEDIATELY EXCLUDE FROM THE FOOD ESTABLISHMENT ANY FOOD EMPLOYEE ILL WITH VOMITING OR DIARRHEA. EMPLOYEES MUST BE EXCLUDED FOR AT LEAST 24 HOURS AFTER LAST SYMPTOM.

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 1005231128 of 07/18/23.

Certified Food Protection Manager: JOSHUA TORMOEN

Certification Number: FM14276 Expires: 06/07/26

Inspection report reviewed with person in charge and emailed.

Signed: _____

JOSH TORMOEN
MANAGER

Signed: _____

Jessica Davis
Public Health Sanitarian III
651-201-3961
jessica.davis@state.mn.us