DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

July 6, 2023

Licensee
Highland Path
1925 Norfolk Avenue
Saint Paul, MN 55116

RE: Project Number(s) SL32400015

Dear Licensee:

On June 29, 2023, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the April 6, 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: 651-281-9796

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Electronically Delivered

April 28, 2023

Licensee
Highland Path
1925 Norfolk Avenue
Saint Paul, MN 55116

RE: Project Number(s) SL32400015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 6, 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 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $3,000.00

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

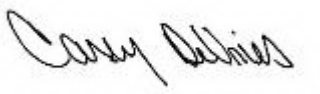
REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd.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



Casey DeVries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 Fax: 651-281-9796

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32400	A. BUILDING: _____ B. WING _____	04/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND PATH	1925 NORFOLK AVENUE SAINT PAUL, MN 55116

(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: SL32400015-0 On April 3, through April 6, 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 150 residents; 77 of whom received services under the provider's Assisted Living with Dementia Care license. On April 4, 2023, an immediate order was issued for 2310. The immediacy was removed on and April 5, 2023, prior to the time of exit on April 6, 2023.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 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 April 4, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies	0 680		

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

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0 680	Continued From page 3 On April 3, 2023, at approximately 11:05 a.m., during the facility tour, the surveyors did not observe an EPP posted prominently. On April 3, 2023, at 11:25 p.m., the surveyors requested to review the licensee's EPP. Licensed assisted living director (LALD)-D indicated the EPP binder was unavailable at this time due to assembling of the EPP binder. On April 3, 2023, at 1:00 p.m., LALD-D provided a 3-ringed binder from the LALD-D's office, undated, and identified the binder as licensee's EPP. LALD-D also retrieved a packet from the front desk and identified the packet as part of the licensee's EPP. The licensee's EPP lacked the following required content: -risk assessment (provided later during survey on April 3, 2023, at 2:30 p.m.); -2022 signed annual review acknowledgement; -missing resident plan quarterly review; -process for EP collaboration; and -policies and procedures (P/P) for tracking staff and patients, medical documents, volunteers, arrangement with other facilities, alternative means for communication, and methods of sharing information. On April 3, 2023, at 2:30 p.m., LALD-D acknowledged the licensee's EPP was not posted prominently and lacked the required content. The licensee lacked a policy related to the content of an EPP to indicate all required elements of Appendix Z. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 680		

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0 680	Continued From page 4 (21) days	0 680		
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been	0 730		

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0 730	Continued From page 5 provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record included documentation of all services provided for residents who received 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On April 4, 2023, at 9:08 a.m., unlicensed personnel (ULP)-B stated they documented services on their Daily Assignment forms. On April 4, 2023, at 1:00 p.m., licensed assisted living director (LALD)-D stated services were all documented on the resident's Daily Assignment form used by the ULP's during their shift. LALD-D stated they saved every Daily Assignment form so in the event someone claims they did not receive	0 730		

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0 730	Continued From page 6 a service they could go back and review the documentation. LALD-D stated they did not have a formal sign-off log. On April 4, 2023, at 1:35 p.m., DON-F provided stacks of Daily Assignment forms stating there were a lot and could just bring the boxes out with all of them. Surveyor stated to only provide the Daily Assignment forms from March and April, 2023, for the 5 residents under review (R1, R2, R3, R4, R5). DON-F stated services were all documented on the forms and they would soon transition from paper documentation to electronic documentation through Rtask. DON-F stated the documentation was confusing and not ideal. 500+ pages of Daily Assignment service administration documentation forms (for residents R1, R2, R3, R4 and R5) were provided by the facility which listed services, treatments and documentation of the completion for those services and treatments during the shift. The Daily Assignment forms were not exclusive to one resident, rather they contained multiple residents' personal information, services, treatments and documentation. ULP would write their initials next to what services or treatment were completed and authenticate the services and treatments were completed by providing their signature. Not all residents on the form were assigned to the ULP during their shift, so cross reference with additional forms was required to determine exactly which residents the ULP was in charge of during the shift. The review provided below identifies known missed services and treatments based on handwritten notes and initials of the assigned ULP. Due to the large volume and disorganization of the documentation a sample of the Daily Assignment forms were selected for review with the findings below.	0 730		

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0 730	Continued From page 7 The "Daily Assignment AL AM 3," form dated March 21, 2023, had missing staff initials for residents being documented on which included: courtesy escorts, home making, standard assistance, laundry, 2-hour checks and snacks. Further the Daily Assignment form lacked an authentication signature required from the ULP staff assigned to the residents, "I certify that the above services were delivered as noted above," to verify the services had been provided. The "Daily Assignment AL PN 1," form dated March 24, 2023, had missing staff initial for residents being documented on which included: 2-hour checks, basic linen change, watching resident take medications due to history of pocketing pills, medication administration. Further, it lacked an authentication signature required from the ULP staff assigned to the residents, "I certify that the above services were delivered as noted above," to verify the services had been provided. The "Daily Assignment AL AM 1," form dated March 25, 2023, lacked an authentication signature required from the ULP staff assigned to the residents, "I certify that the above services were delivered as noted above," to verify the services had been provided. The "Daily Assignment AL PM 1," form dated March 26, 2023, had missing staff initials for residents being documented on which included: grooming cues, medication administration, campus escort, watching resident take all of her medications due to a history of pocketing pills. Further it lacked an authentication signature required from the ULP staff assigned to the residents, "I certify that the above services were	0 730		

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0 730	Continued From page 8 delivered as noted above," to verify the services had been provided. The "Daily Assignment AL NOC," form dated March 26 and 27, 2023, lacked an authentication signature required from the ULP staff assigned to the residents, "I certify that the above services were delivered as noted above," to verify the services had been provided. The "Daily Assignment AL AM 1," form dated March 28, 2023, lacked an authentication signature required from the ULP staff assigned to the residents, "I certify that the above services were delivered as noted above," to verify the services had been provided. On April 4, 2023, at 2:08 p.m., DON-F stated the Daily Assignment forms were used by the ULP to document services they provided to their assigned residents for their shift. DON-F stated the Daily Assignment forms were not exclusive to just one resident, rather included multiple residents on the same form. However, just because a resident was on the Daily Assignment form did not mean the ULP was taking care of them on that date. DON-F stated a cross reference with additional Daily Assignment forms used by other ULP's would need to be done to determine if a resident received their services. DON-F stated ULP's were required to initial each service after being completed and authenticate the Daily Assignment form with their signature at the bottom of the form. The licensee failed to document completion of services, identified in the resident service plan, in each individual resident's record. The licensee's MN AL Service Plan Policy dated	0 730		

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0 730	Continued From page 9 August 1, 2021, indicated, "The facility will implement and provide all services required by the current service plan unless unable for reasons such as, but not including resident refusal." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
0 780 SS=E	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated;	0 780		

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0 780	Continued From page 10 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide working smoke alarms and/or interconnection of smoke alarms in resident apartment units, 116, 202, 209, and 321. This has the potential to directly affect the residents in those units. 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: On April 6, 2023, approximately from 11:00 a.m. to 2:00 p.m., survey staff toured the facility with the regional engineering manager (REM)-H and the environmental services director (ESD)-G). During the tour, survey staff observed the following: 1. The smoke alarm located inside the memory care unit 116 failed to sound when the ESD-G tested the smoke alarm. 2. The smoke alarm located outside the sleeping rooms of apartment unit 202 failed to sound when the ESD-G tested the smoke alarm. The ESD-G confirmed the finding as he investigated the alarm and the battery was missing from inside the smoke alarm unit. 3. The smoke alarms in the one-bedroom apartment unit 209 were not interconnected as required. The finding was evident when the	0 780		

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0 780	Continued From page 11 ESD-G tested the smoke alarms by activating a smoke alarms and each alarm sounded local. 4. Both smoke alarms in apartment unit 321 failed to sound when the ESD-G tested the smoke alarms. All deficiencies were visually and verbally verified with the ESD-G and the REM-H accompanying the tour. On April 6, 2023, at approximately 3:15 p.m., during the exit interview, the licensed assisted living director-A, the REM-H, and the ESD-G acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment of the facility in a continuous state of good repair and operation. This has the potential to directly affect the health, safety, and well-being of all residents	0 800		

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0 800	Continued From page 12 and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On April 6, 2023, approximately from 11:00 a.m. to 2:00 p.m., survey staff toured the facility with the regional engineering manager (REM)-H and the environmental services director (ESD)-G. During the tour, survey staff observed the following: 1. The set of 1-1/2-hour fire-rated doors on the third floor (adjacent to the apartment link units) failed to positively latch when closed preventing the fire-rated doors from properly closing during a fire as designed. 2. The set of 20-minute fire-rated doors between the 3rd-floor wellness center and the corridor failed to positively latch when closed preventing the fire-rated doors to protect and maintaining the smoke-tight integrity of the corridor. 3. The latches for the fire-rated 18-inch by 18-inch trash chute protective covers were taped over with duct tape to prevent the covers from positively latching when closed which compromised the fire rating of the multi-story vertical openings. 4. A bookcase was improperly located in front of an exit door of the memory care day room. Obstruction of an exit door impedes and delay	0 800		

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0 800	Continued From page 13 egress for resident and staff during a fire and similar emergency. Survey staff explained to the ESD-G and the REM-H the door clearly discharges onto the front sidewalk and public way and also with the words "Exit" next to it. In addition, the facility evacuation floor layout showed that the door is an exit door. The ESD-G stated that the bookcase was placed in front of the door as a distraction measure to prevent the memory care residents from continuously pushing the door. All listed deficiencies were visually and/or verbally verified by the ESD-G and the REM-H accompanying the tour. On April 6, 2023, at approximately 3:20 p.m., the licensed assisted living director-D, the REM-H, and the ESD-G acknowledged the above findings. The LALD-D commented that the bookcase in the memory care was located next to the exit door because of resident activity. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for	0 810		

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0 810	Continued From page 14 residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to provide the complete content of the fire safety and evacuation plan. This has the potential to directly affect the safety of all residents receiving services, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	0 810		

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0 810	Continued From page 15 or has the potential to affect a large portion or all of the residents). The findings include: On April 6, 2023, approximately from 11:00 a.m. to 2:00 p.m., survey staff toured the facility with the regional engineering manager (REM)-H and the environmental services director (ESD)-G. On April 6, 2023, at approximately 2:15 p.m. survey staff received the facility fire safety and evacuation plan and related documentation for review from the licensed assisted living director (LALD)-D and the REM-H. At approximately 3:00 p.m., document review and interview with the LALD-D, REM-H, and the environmental services director (ESD)-G indicated the evacuation floor layout was incomplete. The plan layout lacked locations and numbers of resident rooms on the second and 3rd-floor apartment link with the assisted living residences. During the interview, the REM-H and the LALD-D verified that the fire safety and evacuation plan for the facility lacked these provisions. On April 6, 2023, at approximately 3:10 p.m., during the exit interview, the LALD-D, the ESG-G, and the REM-H acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 950 SS=F	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility	0 950		

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0 950	Continued From page 16 must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure resident records included the designation of representatives verbatim statutory language notice for five of five residents (R1, R2, R3, R4, R5). Further, the designation of representative verbatim language was not on its own document separate from the contract.	0 950		

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0 950	Continued From page 17 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1's current contract was signed on December 12, 2022. R2's current contract was signed on February 17, 2023. R3's current contract was signed on October 1, 2022. R4's current contract was signed on October 1, 2022. R5's current contract was signed on October 1, 2022. R1, R2, R3, R4 and R5's records lacked the required verbatim designation of representative language. Further, the designation of representative was not on its own document separate from resident contracts. The following verbiage was used in all five resident contracts listed above: "Designated Representative. For Care Environments only. The person(s) listed as Designated Representative has been designated by Resident to be involved with Owner on behalf of Resident. The Designated Representative's duties and obligations are to assist Resident in fulfilling Resident's financial obligations under this	0 950		

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0 950	Continued From page 18 Agreement in full and on time, to assist Resident to comply with the terms of this Agreement in other respects, and to otherwise assist Resident in Resident's tenancy at the Community, including vacating the Apartment. A Designated Representative-also can assist Resident, receive certain information and notices about Resident, including some information related to Resident's health care, and advocate on Resident's behalf. Resident may change or remove the designated representative at any time. By signing this Residency Agreement, Resident(s) (1) acknowledge receipt of the Notice titled "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES", and (2) authorize Owner and its representatives to communicate with the Designated Representative about Resident(s) personal and confidential information, including health information." On April 5, 2023, at 11:01 a.m., licensed assisted living director (LALD)-D acknowledged the required verbatim notice was not included in the licensee's assisted living contract. Later at 12:00 p.m., during the exit meeting, LALD-D and director of nursing (DON)-F explained they did not fully understand the statutory requirement. The surveyor explained it was missing statute required verbatim language and was not its own document separate from the contract. The licensee's MN AL Admission and Discharge Checklist indicated during the Residency Agreement Appointment the resident or resident representative would provide, "Legal Representative/POA Forms (as applicable) - we will make a copy." No further information was provided.	0 950		

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0 950	Continued From page 19 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950		
01540 SS=D	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of two employees (unlicensed personnel (ULP)-B) completed the required eight (8) hours of dementia care training within 80 hours of employment start date. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of	01540		

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01540	Continued From page 20	01540		

residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).
The findings include:

ULP-B was hired on January 10, 2023, and was observed by the surveyor to provide direct care services to residents on April 4, 2023, at 8:48 a.m.

ULP-B's employee record lacked documentation of the required 8 hours of dementia care training withing 80 hours of employment start date. ULP-B had completed four (4) hours of dementia training on February 20, 2023, and an additional 4 hours on April 3, 2023.

On April 4, 2023, at 11:34 a.m., ULP-B stated she was asked to complete an additional 4 hours of dementia training on April 3, 2023, during the survey. ULP-B stated she was a full-time employee and had worked her full-time schedule since her date of hire.

On April 4, 2023, at 2:08 p.m., director of nursing (DON)-F stated the required dementia training was completed late on April 3, 2023.

The licensee's Dementia Training Policy dated August 1, 2021, indicated:
"1) Initial Orientation
a) Dementia training will include:
i) An explanation of Alzheimer's disease and other dementias
ii) Assistance with activities of daily living
iii) Problem solving with challenging behaviors
iv) Communication Skills
v) Person-centered planning and

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01540	Continued From page 21 service delivery 2) Employees who have not completed their initial dementia care training will not provide direct care independently: a) There will be another employee onsite while this employee is working who: i) Has completed the initial eight hours of training on topics related to dementia care ii) Will serve as a resource for the employee who has not completed all of the initial dementia care training" No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01540		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees	01640		

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01640	Continued From page 22 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 the current service plan included a signature or other authentication by resident or resident representative to document agreement on the services to be provided for one of five residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted on June 5, 2022. R1's Service Plan Attachment E to Residency Agreement signed December 19, 2022, was identified by licensed assisted living director (LALD)-D as R1's most currently authenticated service plan. On April 3, 2023, at approximately 12:30 p.m., the surveyor observed R1's schedule services via the licensee's electronic chart (RTasks), which indicated as R1's current service plan with services R1 was receiving. The Rtask service plan included seven identified services which were revised after the signed service plan dated	01640		

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01640	Continued From page 23 December 19, 2022. The service plan revisions were as follows: -linen change three days a week added December 21, 2022; -bed mobility/repositioning daily added April 3, 2023; -behavior management daily added February 24, 2023; -exercise/walking program four times a week added February 24, 2023; -information only four times a week added January 9, 2023; -laundry three times a week added December 21, 2022; and -sensory communication daily added January 9, 2023. On April 3, 2023, at approximately 3:00 p.m., LALD-D stated the licensee's expectation was all current service plans to be signed by the RN who completed the document and then the resident or the resident's designated representative. LALD-D stated licensee had completed R1's service plan but was unsure why licensee did not sign or obtain the resident's authentication after revisions. The licensee's MN AL Service Plan policy dated August 1, 2021, indicated any changes to the resident's service plan or agreement must be signed by the resident or the resident's representative and the licensee's representative. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		

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01730	Continued From page 24	01730		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes.	01730		

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01730	Continued From page 25 (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an individualized medication management record with the required content for one of five 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) 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 90-day Nursing Assessment dated March 2, 2023, indicated R4 had a diagnosis of diabetes type 2. R4's service agreement dated March 2, 2023, indicated R4 received insulin administration services. R4's record had medication orders signed on October 14, 2022, for insulin aspart three (3) times per day as follows: - insulin aspart 100unit (u)/milliliter (ml), inject 12u with meal, subcutaneously (into fatty tissue), one (1) time daily at 7:15 a.m., for type two (2) diabetes. Check blood glucose (BG). If the BG is less than 100 or greater than 250, call the nurse;	01730		

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01730	Continued From page 26 - insulin aspart 100u/ml, inject 4u with meal, subcutaneously, 1 time daily at 11:30 a.m., for type 2 diabetes. Check BG. If the BG is less than 100 or greater than 250, call the nurse; and - insulin aspart 100u/ml, inject 10u with meal, subcutaneously, 1 time daily at 4:30 p.m., for type 2 diabetes. Check BG. If the BG is less than 100 or greater than 250, call the nurse. R4's 90-day Nursing Assessment dated March 2, 2023, included an individualized medication management plan. The individualized medication management plan, orders, and medication administration record (MAR) for March and April 2023, lacked the following: - documentation of specific resident instructions relating to the administration of medications. On April 3, 2023, at 12:25 p.m., R4 stated they were tired of waiting for ULP-C to check their BG and began eating lunch which included meatballs with a white cream sauce, noodles, and cooked carrots. On April 3, 2023, at 2:45 p.m., ULP-C stated they were very behind with providing services and medication administration on the morning of April 3, 2023. ULP-C stated they did eventually check R4's BG sometime after 12:30 p.m., and although they knew R4 had already eaten their lunch, administered R4's insulin anyway based on the BG result of 249. ULP-C stated they had been trained on insulin administration when hired and thought insulin could be administered based off a BG reading taken after a resident had already eaten. On April 3, 2023, at 2:50 p.m., registered nurse (RN)-E, who was present for the interview with ULP-C, stated the expectation was for ULP's to	01730		

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01730	Continued From page 27	01730		

contact the nurse if a resident had already eaten their meal prior to their BG checks. RN-E stated there should be instructions on the MAR for ULP's to follow in the event a resident ate prior to having their BG taken and acknowledged there was a lack of instruction for the ULP's to follow on R4's MAR.

On April 4, 2023, at 11:01 a.m., director of nursing (DON)-F stated the expectation was for the ULP to contact the nurse if a resident had already eaten prior to BG checks and the administration instructions should reflect as such.

The licensee's MN AL Medication Management Policy dated July 18, 2022, indicated:
"15. Delegation of Medication Related Tasks - A Registered Nurse may delegate medication administration to resident assistants only after the RN has:
a. Verified the resident assistant is educated and trained in the proper methods to administer the medications, and the resident assistant has demonstrated the ability to competently follow the procedures;
b. Developed specific written instructions for each resident and documented those instructions in the resident's medication record/MAR; and
c. Communicated with the resident assistant about the individual needs of the resident.
d. The medication is in the original pharmacy-dispensed container with a proper label and directions, in the original over-the-counter container, bubble pack, or the medication has been removed from the original container and placed in a unit container by a licensed nurse."

TIME PERIOD FOR CORRECTION: Seven (7) days

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01760 SS=D	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 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 administer medication per provider orders for one of five 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) 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 service agreement dated March 2, 2023, indicated R4 received insulin administration services.	01760		

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01760	Continued From page 29	01760		

R4 had a medication order signed on October 14, 2022, for insulin aspart 100unit (u)/milliliter (ml), inject 4u with meal, subcutaneously (into fatty tissue), one (1) time daily at 11:30 a.m. for type two (2) diabetes. Check blood glucose (BG). If the BG is less than 100 or greater than 250, call the nurse.

On April 3, 2023, at 12:00 p.m., surveyor went to R4's room to observe insulin administration. R4 stated staff were late for his 11:30 a.m. BG check and insulin administration. R4 stated staff were also late earlier in the morning on April 3, 2023, to check his BG and to administer insulin.

On April 3, 2023, at 12:13 p.m., R4 stated they were tired of waiting for staff to check their BG and the surveyor observed R4 leave their room to get their food from the dining room.

On April 3, 2023, at 12:17 p.m., R4 and the surveyor informed registered nurse (RN)-E the unlicensed personnel (ULP)-C had not arrived to check R4's BG and administer their insulin. RN-E stated she would reach out to ULP-C immediately.

On April 3, 2023, at 12:20 p.m., the surveyor observed R4 return to their room. R4 stated staff were late on a regular basis with medication and BG checks. ULP-C had not yet arrived.

On April 3, 2023, at 12:25 p.m., R4 stated they were tired of waiting for ULP-C to check their BG and began eating lunch which included meatballs with a white cream sauce, noodles, and cooked carrots.

On April 3, 2023, at 12:32 p.m., R4 finished eating their lunch.

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01760	Continued From page 30 On April 3, 2023, at 12:47 p.m., the surveyor left R4's room, ULP-C had still not arrived to check R4's BG. On April 3, 2023, at 2:45 p.m., ULP-C stated they were very behind with providing services and medication administration earlier in the day. ULP-C stated they were reassigned in the mid-morning and later notified nursing they were running behind. ULP-C stated they did eventually check R4's BG sometime after 12:30 p.m., and although they knew R4 had already eaten, administered R4's insulin. ULP-C stated they were trained on insulin administration when hired and thought insulin could be administered based off a BG reading taken after a resident had already eaten. On April 3, 2023, at 2:50 p.m., RN-E, who was present for the interview with ULP-C, stated the expectation was for ULP's to contact the nurse if a resident had already eaten prior to their BG checks. RN-E stated there should be instructions on the MAR for ULP's to follow in the event a resident ate prior to having their BG checked, and it was not typical for insulin to still be administered if BG was checked after a resident ate. RN-E acknowledged there was a lack of instruction for the ULP's to follow on R4's MAR for BG checks and insulin administration. On April 3, 2023, at 3:13 p.m., RN-I showed a text conversation between themself and ULP-C which indicated ULP-C needed to go and give R4 their insulin. RN-I stated they did not know R4 had already eaten his lunch when they told ULP-C to go and administer R4's insulin, had they known they still likely would have told ULP-C to administer the insulin. RN-E stated BG checks	01760		

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01760	Continued From page 31 should be done before a resident eats. RN-E stated the medication administration policy did not address insulin administration for the current scenario. No further information provided TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01950 SS=D	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 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) specified, in writing, specific instructions for each resident's treatment,	01950		

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01950	Continued From page 32 and documented those instructions in the resident's record for two of five residents (R4, 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) 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 R4's 90-day Nursing Assessment dated March 2, 2023, indicated R4 had a diagnosis of diabetes type 2. R4's Service Agreement/Treatment Management Plan dated March 2, 2023, indicated R4 received blood glucose (BG) monitoring three (3) times daily. R4's signed orders dated October 14, 2022, and medication administration record (MAR) for March and April 2023, both included BG instructions with R4's insulin orders and indicated, "Check blood sugar. If blood sugar less than 100 or greater than 250 - call the nurse." R4's record lacked instruction of when the BG should be checked. On April 3, 2023, at 12:25 p.m., the surveyor observed R4 waiting for their BG check and insulin administration. R4 stated they were tired of waiting for ULP-C to check their BG and ate lunch which included meatballs with a white cream sauce, noodles, and cooked carrots.	01950		

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01950	Continued From page 33 On April 3, 2023, at 2:45 p.m., ULP-C stated they were very behind with providing services and medication administration. ULP-C stated they did eventually check R4's BG sometime after 12:30 p.m., and although they knew R4 had eaten, administered R4's insulin anyway. ULP-C stated they thought insulin could be administered based off a BG reading taken after a resident had already eaten. On April 3, 2023, at 2:50 p.m., registered nurse (RN)-E, who was present for the interview with ULP-C, stated the expectation was for ULP's to contact the nurse if a resident had already eaten prior to their BG checks. RN-E stated there should be instructions for ULP's to follow in the event a resident ate prior to having their BG taken. RN-E acknowledged there was a lack of BG check instruction for the ULP's to follow on R4's MAR. R5 R5's 90-day Nursing Assessment dated January 3, 2023, indicated R5 had a diagnosis of chronic bilateral lower extremity edema (swelling of legs and feet due to fluid retention) secondary to lymphedema. R5's Service Agreement/Treatment Management Plan dated February 20, 2023, indicated R5 received Ted Hose/Ace Wrap/Velcro Leg Wrap Assistance (compression wrappings for legs to manage edema) two (2) times per day. R5's signed order dated June 8, 2022, indicated, "staff to apply non-stick telfa pad to cover the blisters, and then reapply velcro leg wraps." Instructions for the unlicensed personnel (ULP) for how to apply the velcro wraps was found on	01950		

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01950	Continued From page 34 Daily Assignment forms and indicated, " Apply Farrow wraps [velcro leg wraps] to bilat lower legs." On April 4, 2023, at 9:08 a.m., the surveyor observed ULP-B applying R5's velcro wraps. The velcro wraps were only long enough to cover half the distance from her knee down to her ankle. R5's record lacked instructions of where specifically the velcro wrap should be applied. ULP-B applied the velcro wraps starting at mid-shin level up to R5's knee-cap. ULP-B stated they knew how high up R5's legs to put the velcro wraps because someone showed her. ULP-B stated their Daily Assignment form did not include instruction as to how high or low the velcro wraps should be applied. On April 5, 2023, at 11:01 a.m., director of nursing (DON)-F stated the expectation was for treatments to include specific instructions for administration. The licensee's MN AL Treatment and Therapy Management Policy dated August 1, 2021, indicated: "3. The RN may delegate to resident assistants the task of providing assistance with treatment and therapy if the resident assistants have satisfied the training requirements listed above and if: a. Before performing the procedures, the RN has instructed the resident assistant in the proper methods to administer the treatment and therapy and the resident assistants have demonstrated the ability to competently follow the procedures; b. The RN has developed written, specific instruction for each resident; c. The RN has communicated with the resident assistants about the individual needs of the	01950		

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01950	Continued From page 35 resident; and d. The RN has documented that the resident assistants have been trained and have demonstrated competency to follow the procedures." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on observation, document review, and interview, the licensee failed to develop a safety risk assessment plan to identify hazard vulnerabilities and mitigations on and around the property to protect memory care residents from harm. This has the potential to directly affect all memory care residents receiving assisted living services. This practice resulted in a level two violation (a	02040		

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violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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 clients).

The findings include:

On April 6, 2023, approximately from 11:00 a.m. to 2:00 p.m., survey staff toured the facility with the regional engineering manager (REM)-H and the environmental services director (ESD)-G.

On April 6, 2023, at approximately 2:30 p.m., a document review indicated the license failed to develop the required site-specific safety risk assessment and mitigation plan on and around the property to protect the memory care residents from harm. This finding was evident as there was no site-specific plan documentation provided for review. The finding was confirmed during the interview at approximately 3:30 p.m. with the licensed assisted living director (LALD)-D, the REM-H, and the ESD-G that the facility lacked a plan that is site-specific to protect the memory care residents.

On April 6, 2023, at approximately 3:40 p.m., during the exit interview, survey staff discussed the finding and explained to the LALD-D, ESD-G, and the REM-H that all potential safety risks or vulnerabilities on and around the property including the memory care stovetop oven in the common area must be identified, assessed, and mitigated and be documented in the plan documentation to protect the memory care residents from harm. The LALD-D and the

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02040	Continued From page 37 REM-H acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
02110 SS=F	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to	02110		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02110	Continued From page 38 and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the required policies and procedures for assisted living with dementia care (ALFDC) were provided to residents, or the residents' legal and designated representatives, at the time of move in for five of five residents (R1, R2, R3, R4, 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1's current contract was signed on December 12, 2022. R2's current contract was signed on February 17, 2023. R3's current contract was signed on October 1, 2022. R4's current contract was signed on October 1, 2022.	02110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32400	A. BUILDING: _____ B. WING _____	04/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND PATH	1925 NORFOLK AVENUE SAINT PAUL, MN 55116

(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
02110	Continued From page 39 R5's current contract was signed on October 1, 2022. R1, R2, R3, R4 and R5's records lacked evidence the licensee provided the residents, or residents' legal and designated representative, with the dementia care policies required under the ALFDC license. On April 4, 2023, at 4:22 p.m., licensed assisted living director (LALD)-D stated they were using a new "Acknowledgements" form for residents, or residents' representatives, to acknowledge they received required documents upon admission. R1 and R4's record included the form, but it did not address dementia care policies. On April 5, 2023, at 4:33 p.m., LALD-D's email indicated dementia training notification requirements were provided in the Resident Handbook, on page 14 of 36, and the citation should be removed. Surveyor responded via email and indicated the dementia training notification satisfied a portion of the statute, however, the statute included the following additional policies and procedures not addressed in the Resident Handbook: -philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; -evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; -wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; -medication management, including an assessment of residents for the use and effects	02110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32400	A. BUILDING: _____ B. WING _____	04/06/2023

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HIGHLAND PATH	1925 NORFOLK AVENUE SAINT PAUL, MN 55116

(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
02110	Continued From page 40 of medications, including psychotropic medications; -description of life enrichment programs and how activities are implemented; -description of family support programs and efforts to keep the family engaged; -limiting the use of public address and intercom systems for emergencies and evacuation drills only; -transportation coordination and assistance to and from outside medical appointments; -safekeeping of residents' possessions; and -the policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02110		
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care standards, medical or nursing standards for three of three residents (R1, R7, R8) who utilized side rails.	02310	On April 5, 2023, the immediacy of correction order 2310 was removed, however non-compliance remained at a scope and level of I.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32400	A. BUILDING: _____ B. WING _____	04/06/2023

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02310	Continued From page 41 This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 On April 3, 2023, at approximately 12:00 p.m., during care observation, the surveyor observed raised bilateral (both sides of the bed) consumer Halo side rails on R3's occupied hospital bed. R1 was admitted to the licensee on June 5, 2022. R1's Service Plan - Attachment E to Residency Agreement, which director of nursing (DON)-F indicated is the service agreement, dated December 19, 2022, indicated R1 received services including medication management, bath assist, transfer assist, and escort. R1's RN assessment dated March 31, 2023, did not include a side rail assessment. R1's medical record lacked documentation of the following: -a completed side rail assessment; -the risks and benefits were discussed with the resident/responsible party (completed on April 4, 2023, after initiation of the survey) -the portable side rail has not been recalled by the Consumer Product Safety Commission (CPSC); -the portable side rail was installed, used, and	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32400	A. BUILDING: _____ B. WING _____	04/06/2023

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HIGHLAND PATH	1925 NORFOLK AVENUE SAINT PAUL, MN 55116

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02310	Continued From page 42 maintained per manufacturer's guidelines; and -the manufacturer's guidelines were accessible upon request. R7 On April 4,2023, at approximately 3:40 p.m., surveyor observed raised bilateral hospital side rails on R7's hospital bed. R7 was admitted to the licensee on June 5, 2022. R7's Service Plan - Attachment E to Residency Agreement dated March 7, 2023, indicated R7 received services including medication management, bath assist, transfer assist, and escort. R7's RN assessment dated May 20, 2022, did not include a side rail assessment. R7's medical record lacked documentation of the following: -a completed side rail assessment; -the risks and benefits were discussed with the resident/responsible party; -zone measurements per the Food and Drug Administration (FDA) guidelines for zones of entrapment; and -the side rail was FDA compliant. R8 On April 4,2023, at approximately 3:45 p.m., surveyor observed raised bilateral Halo consumer side rails on R8's hospital bed. R8 was admitted to the licensee on June 5, 2022. R8's Service Plan - Attachment E to Residency Agreement dated February 20, 2023, indicated R8 received services including medication	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32400	A. BUILDING: _____ B. WING _____	04/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND PATH	1925 NORFOLK AVENUE SAINT PAUL, MN 55116

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 43	02310		

management, oxygen management, bath assist, and escort.

R8's RN assessment dated March 9, 2023, did not include a side rail assessment.

R8's medical record lacked documentation of the following:
-a completed side rail assessment;
-the risks and benefits were discussed with the resident/responsible party
-the portable side rail has not been recalled by the CPSC;
-the portable side rail was installed, used, and maintained per manufacturer's guidelines; and
-the manufacturer's guidelines were accessible upon request.

On April 4, 2023, at approximately 3:10 p.m., DON-F acknowledged a side rail assessment was not completed for R1, R7, and R8. DON-F also acknowledged a risk and benefit discussion was not completed for R7 or R8 with hospital side rails or consumer side rails. DON-F indicated she did not measure any hospital side rails for compliance with the FDA and did not check for consumer side rail recalls on the CPSC website.

The licensee's Physical Device Policy and Procedure dated June 2018, indicated when the licensee is aware a resident is utilizing side rails on a bed, the licensee will assess the use, educate the resident, and when appropriate, the responsible person, regarding the risks and benefits of side rails, and verify that the side rail in use of a safe design and utilized consistent with the manufacturer's directions.

The FDA's A Guide to Bed Safety dated March 10, 2006, indicated licensee would assess the

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02310	Continued From page 44 use, educate the resident, and when appropriate, the responsible person, regarding the risks and benefits of side rails, and verify that the side rail in use is of a safe design and utilized consistent with the manufacturer's directions. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	02310		

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

Type: Full
Date: *04/04/23*
Time: 13:11:42
Report: 1021231075

Food and Beverage Establishment Inspection Report

Location:
Highland Path
1925 Norfolk Avenue
St. Paul, MN55116
Ramsey County, 62

Establishment Info:
ID #: N032400
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #:
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.

4-600 Cleaning Equipment and Utensils

4-601.11A ** Priority 2 **

MN Rule 4626.0840A Equipment food-contact surfaces and utensils must be clean to sight and touch.

CAN OPENER BLADE CONTAINS SHAVINGS OF CAN LABELS. STAFF SENT THE CAN OPENER TO THE DISH MACHINE DURING INSPECTION. CORRECTED ON-SITE. CLEAN AND SANITIZE THE CAN OPENER AFTER EACH USE.

Comply By: 04/04/23

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.12A

MN Rule 4626.1520A Clean and maintain all physical facilities clean.

FLOOR UNDER THE COOKING EQUIPMENT (UNDER THE VENTILATION HOOD) CONTAINS ACCUMULATION OF DRIED FOOD DEBRIS AND GREASE. WALL BEHIND THE NORLAKE UPRIGHT COOLER CONTAINS DUST ACCUMULATION. CLEAN AND MAINTAIN CLEAN.

Comply By: 04/11/23

Surface and Equipment Sanitizers

Sink & Surface Sanitizer: = 700PPM at Degrees Fahrenheit
Location: THREE COMPARTMENT SINK DISPENSER
Violation Issued: No

Final Utensil Surface Temp: = at 169 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Sink & Surface Sanitizer: = 272PPM at Degrees Fahrenheit
Location: SANI BUCKET, PREP AREA
Violation Issued: No

Final Utensil Surface Temp: = 272PPM at Degrees Fahrenheit
Location: SANI BUCKET, COOKS LINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Hot Holding
Temperature: 203 Degrees Fahrenheit - Location: BROWN RICE - HOT WELLS
Violation Issued: No

Process/Item: Hot Holding
Temperature: 163 Degrees Fahrenheit - Location: MASHED POTATOES - HOT WELLS
Violation Issued: No

Process/Item: Hot Holding
Temperature: 189 Degrees Fahrenheit - Location: BEEF STEW - HOT WELLS
Violation Issued: No

Process/Item: Cold Holding
Temperature: 35 Degrees Fahrenheit - Location: SLICED TOMATO - ADVANTEDGE PREP COOLER, COLD WELLS
Violation Issued: No

Process/Item: Cold Holding
Temperature: 37 Degrees Fahrenheit - Location: CUT LETTUCE - ADVANTEDGE PREP COOLER, COLD WELLS
Violation Issued: No

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: CUT MELON - NORLAKE UPRIGHT COOLER
Violation Issued: No

Process/Item: Cooking
Temperature: 198 Degrees Fahrenheit - Location: MIXED VEGETABLES - STEAMER
Violation Issued: No

Process/Item: Re-Heating
Temperature: 181 Degrees Fahrenheit - Location: GRILL CHEESE - FLAT TOP GRILL
Violation Issued: No

Process/Item: Cold Holding
Temperature: 38 Degrees Fahrenheit - Location: CHICKEN WILD RICE SOUP - WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Holding
Temperature: 36 Degrees Fahrenheit - Location: MILK - WALK-IN COOLER
Violation Issued: No

Type: Full
Date: *04/04/23*
Time: 13:11:42
Report: 1021231075
Highland Path

Food and Beverage Establishment Inspection Report

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: SALAD - NORLAKE 2 DOOR UPRIGHT COOLER
Violation Issued: No

Process/Item: Hot Holding
Temperature: 165 Degrees Fahrenheit - Location: TOMATO BASIL SOUP - SOUP WELL
Violation Issued: No

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: MILK - MEMORY CARE REFRIGERATOR
Violation Issued: No

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

ALL FINDINGS ON THIS REPORT WERE DISCUSSED WITH CULINARY DIRECTOR, TIMOTHY POHLAND AND HEALTH REGULATION DIVISION NURSE EVALUATORS, JOEY KEEN AND CARL SAMROCK.

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 1021231075 of 04/04/23.

Certified Food Protection Manager: TIMOTHY N. POHLAND

Certification Number: FM32454 Expires: 05/21/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
TIMOTHY POHLAND
CULINARY DIRECTOR

Signed: _____
Melissa Ramos
Environmental Health Specialist
Metro District Office
651-201-4495
Melissa.Ramos@state.mn.us