DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically Delivered

February 20, 2024

Licensee
Cosmo Home Healthcare Services
3935 5th Avenue South
Minneapolis, MN  55407

RE: Project Number(s) SL36196015

Dear Licensee:

On February 6, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the November 15, 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,

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

HHH

Electronically Delivered

December 27, 2023

Licensee
Cosmo Home Healthcare Services
3935 5th Avenue South
Minneapolis, MN  55407

RE:  Project Number(s) SL36196015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on November 15, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

**STATE CORRECTION ORDERS**

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

**IMPOSITION OF FINES**

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

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

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

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

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

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

**St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00**
**St - 0 - 0820 - 144g.45 Subd. 2 (g) - Fire Protection And Physical Environment -$3,000.00**
**St - 0 - 1130 - 144g.55 Subd. 2 - Safe Location -$3,000.00**

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $6,500.00**. 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.

To submit a reconsideration request, please visit:

**https://forms.web.health.state.mn.us/form/HRD-Appeals-Form**

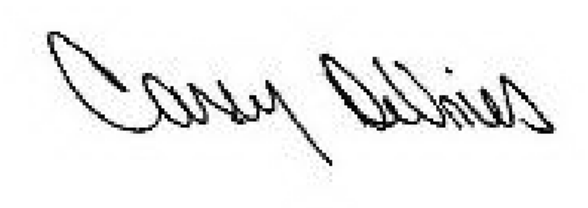
**REQUESTING A HEARING**
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and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

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

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

If you have any questions, please contact me.

Sincerely,



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

HHH

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 36196 | A. BUILDING: _____ B. WING _____ | 11/15/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COSMO HOME HEALTHCARE SERVICES | 3935 5TH AVENUE SOUTH MINNEAPOLIS, MN 55407 |

| (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 |
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| 0 000 | Initial Comments<br><br>******ATTENTION******<br><br>ASSISTED LIVING PROVIDER CORRECTION ORDER<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation.<br><br>Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance.<br><br>INITIAL COMMENTS:<br><br>SL36196015-0<br><br>On November 13, 2023, through November 15, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were three (3) residents receiving services under the Assisted Living license.<br><br>An immediate correction order was identified on November 13, 2023, issued for SL36196015-0, tag identification 0820.<br><br>On November 14, 2023, the immediacy of correction order 0820 was removed, however non-compliance remained, and the scope and level remained unchanged. | 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.<br><br>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.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>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. | |
| 0 470 SS=F | 144G.41 Subdivision 1 Minimum requirements | 0 470 | | |

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| 0 470 | Continued From page 1<br><br>(11) develop and implement a staffing plan for determining its staffing level that:<br>(i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility;<br>(ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and<br>(iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility;<br>(12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be:<br>(i) awake;<br>(ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time;<br>(iii) capable of communicating with residents;<br>(iv) capable of providing or summoning the appropriate assistance; and<br>(v) capable of following directions;<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to review their staffing plan two times annually to determine if staffing levels met the needs of all residents. Further, the licensee failed to ensure the required staffing schedule was posted for residents, staff, and visitors to review.<br><br>This practice resulted in a level two violation (a | 0 470 | | |

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| 0 470 | Continued From page 2<br><br>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).<br><br>The findings include:<br><br>The licensee's Facility Staffing Plan, prepared by clinical nurse supervisor (CNS)-A, indicated staffing requirements for November 10-21, 2023, were one staff member for each the day, evening, and overnight shifts. The staffing plan lacked dates of review or when it was last updated to show it had been reviewed twice annually.<br><br>On November 13, 2023, at 10:15 a.m., during the entrance conference, licensed assisted living director (LALD)-D and owner (O)-F stated they had a staffing plan evaluated two times a year and a staff schedule posted for residents on the main floor.<br><br>On November 13, 2023, at 11:15 a.m., during the facility tour, the surveyor observed the licensee lacked a posted staffing schedule. LALD-D stated the staffing schedule was not posted.<br><br>On November 14, 2023, at 11:03 a.m., LALD-D stated they did not know when the Facility Staffing Plan provided to the surveyor by the licensee was last updated.<br><br>The licensee's Facility Staffing Plan, undated, indicated:<br>"The staffing plan considered the following requirements: | 0 470 | | |

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| 0 470 | Continued From page 3<br><br>-Individual resident needs and acuity level based on the assessment, Service Plan and Assisted living contract<br>-Staff ability to respond promptly to scheduled and unscheduled needs of residents and considering the physical layout of the facility<br>-Education, competence and experience of scheduled staff<br>-Requirements related to missing resident policy<br>-Requirements related to emergency preparedness plan<br>The staffing schedule:<br>-Includes direct-care staff<br>-Identifies assignment/work location<br>-Is posted at the beginning of each work shift in a central location of the facility accessible to staff, residents and the public"<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 470 | | |
| 0 480 SS=F | 144G.41 Subd 1 (13) (i) (B) Minimum requirements<br><br>(13) offer to provide or make available at least the following services to residents:<br>(B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This had the potential to affect all | 0 480 | | |

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| 0 480 | Continued From page 4<br>residents of the assisted living facility.<br><br>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).<br><br>The findings include:<br><br>Please refer to the included document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated November 13, 2023, for the specific Minnesota Food Code deficiencies. The Inspection Report was provided to the licensee within 24 hours of the inspection.<br><br>TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates. | 0 480 | | |
| 0 510 SS=F | 144G.41 Subd. 3 Infection control program<br><br>(a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control.<br>(b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities.<br>(c) The facility must maintain written evidence of compliance with this subdivision. | 0 510 | | |

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| 0 510 | Continued From page 5<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program that complied with accepted health care, medical and nursing standards for infection control. The deficient practice had the potential to affect all residents, employees, and visitors.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>On November 13, 2023, at 10:00 a.m., the surveyor observed the main floor bathroom lacked soap and hand towels for drying. The surveyor observed an empty soap pump dispenser mounted on the wall.<br><br>On November 13, 2023, at 11:15 a.m., during the facility tour, the surveyor observed the main floor bathroom continued to lack hand towels and soap.<br><br>On November 13, 2023, at 2:40 p.m., the surveyor observed the main floor bathroom continued to lack hand towels and soap, and the sink vanity countertop was covered with water.<br><br>On November 14, 2023, at 11:00 a.m., the surveyor observed the main floor bathroom | 0 510 | | |

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| 0 510 | Continued From page 6<br><br>continued to lack hand towels and soap. Unlicensed personnel (ULP)-B stated they were aware the bathroom soap dispenser was empty and the bathroom lacked hand drying towels. ULP-B stated, "Isn't the soap filled already? I thought [LALD-D] did that already." ULP-B stated licensed assisted living director (LALD)-D was working on correcting the situation.<br><br>On November 14, 2023, at 11:03 a.m., LALD-D acknowledged the bathroom had been without soap or hand towels for the past two days. LALD-D stated they had meant to refill the soap dispenser and put out more paper towels but had been unable to due to the survey. LALD-D stated the bathroom should never be without soap or hand drying towels.<br><br>The licensee's 8.01 Infection Control Policy dated August 1, 2021, which lacked customization with the licensee's name, indicated, "[Name of AL]'s infection control program will be consistent with current guidelines from CDC for prevention control in long-term care facilities, where applicable in assisted living facilities."<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Two (2) days | 0 510 | | |
| 0 550 SS=F | 144G.41 Subd. 7 Resident grievances; reporting maltreatment<br><br>All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. | 0 550 | | |

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| 0 550 | Continued From page 7<br><br>The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to post the required information related to the grievance procedure, reporting contact information for the Office of Ombudsman for Long-Term Care (OOLTC), the Office of Ombudsman for Mental Health and Developmental Disabilities (OMHDD), Minnesota Adult Abuse Reporting Center (MAARC) and Office of Health Facility Complaints (OHFC).<br><br>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).<br><br>The findings include:<br><br>On November 13, 2023, at 11:00 a.m., during the facility tour, the surveyor observed the facility's main entrance and commons area which lacked the following required postings: | 0 550 | | |

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| 0 550 | Continued From page 8<br>- OOLTC;<br>- OMHDD;<br>- MAARC; and<br>- OHFC.<br><br>On November 13, 2023, at 11:00 a.m., licensed assisted living director (LALD)-D stated they did not have the above-mentioned required postings. They stated, "residents do not like to write grievances; they usually call us when they have problems". Owner (O)-F stated they had a grievance form in the policy manual which was kept in the basement office. O-F stated they did not have the required postings anywhere in the facility.<br><br>The licensee's Common Postings policy, undated, indicated:<br>"GRIEVANCE:<br>A copy of the grievance procedure is conspicuously posted in the residence with the following information:<br>Name, phone number and email contact information for the individuals who are responsible for handling resident complaints<br>Contact information for the state and any regional Office of Ombudsman for Long-Term-Care<br>Contact information for the Office of Ombudsman for Mental Health and Developmental Disabilities<br>Contact information for the Minnesota Adult Abuse Reporting Center<br>Contact information for the Minnesota Department of Health, Office of Health Facility Complaints if an individual has a complaint about the facility or person providing services."<br><br>No further information was provided. | 0 550 | | |

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| 0 550 | Continued From page 9<br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 550 | | |
| 0 570 SS=C | 144G.42 Subdivision 1 Display of license<br><br>The original current license must be displayed at the main entrance of each assisted living facility. The facility must provide a copy of the license to any person who requests it.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to display their current Assisted Living license at the main entrance of the facility as required. This had the potential to affect all residents, staff, and visitors.<br><br>This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>On November 13, 2023, at 9:50 a.m., the surveyor observed the licensee's current license issued on May 1, 2023, posted in the office space located in the basement of the facility.<br><br>On November 13, 2023, at 11:00 a.m., during the facility tour the surveyor observed the main entrance and common areas lacked the required license posting. | 0 570 | | |

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| COSMO HOME HEALTHCARE SERVICES | 3935 5TH AVENUE SOUTH MINNEAPOLIS, MN 55407 |

| (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 |
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| 0 570 | Continued From page 10<br><br>On November 13, 2023, at 11:05 a.m., licensed assisted living director (LALD)-D stated the license was only posted downstairs in the office space. Owner (O)-F stated they were not aware it had to be posted at the entrance.<br><br>The licensee's Common Postings policy, undated, indicated, "COMMON POSTINGS: All posts must be in accessible area. The Agency License, CLIA, Liability Insurance, & MN Labor Law must be posted."<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 570 | | |
| 0 650 SS=F | 144G.42 Subd. 8 Employee records<br><br>(a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information:<br>(1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules;<br>(2) records of orientation, required annual training and infection control training, and competency evaluations;<br>(3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision;<br>(4) documentation of annual performance reviews that identify areas of improvement needed and training needs;<br>(5) for individuals providing assisted living services, verification that required health | 0 650 | | |

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| 0 650 | Continued From page 11<br><br>screenings under subdivision 9 have taken place and the dates of those screenings; and<br>(6) documentation of the background study as required under section 144.057.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure employee records contained required documentation of completed training for medication management for unplanned times away when a licensed nurse is not available for one of one employee (unlicensed personnel (ULP)-B).<br><br>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).<br><br>The findings include:<br><br>ULP-B was hired on May 1, 2023, to provide direct care to residents.<br><br>On November 14, 2023, at 9:12 a.m., the surveyor observed ULP-B administer medications to R2.<br><br>On November 14, 2023, at 9:12 a.m., ULP-B stated they were trained to setup medications for resident unplanned times away and was able to talk the surveyor through the process.<br><br>ULP-B's employee record lacked documentation they were trained to setup medications for | 0 650 | | |

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| 0 650 | Continued From page 12<br>residents for unplanned times away.<br><br>On November 15, 2023, at 9:37 a.m., licensed assisted living director (LALD)-D provided the surveyor with ULP-B's Educare (online training platform) transcript and stated ULP-B's unplanned times away training was included on the transcript. The surveyor requested for LALD-D show where the training was located on the transcript, LALD-D acknowledged it wasn't on the transcript and stated the training was not being completed with any of the ULP's.<br><br>On November 15, 2023, at 1:55 p.m., clinical nurse supervisor (CNS)-A stated if a resident wanted to leave the facility for unplanned times away, the nursing staff would try and go to the facility and setup the medications. CNS-A stated if nursing was unable to go to the facility, they would have ULPs conduct the unplanned time away medication setup via a video phone call with the nurse. CNS-A would not say whether or not ULPs were allowed to setup medications on their own.<br><br>The licensee's 7.10 Medication Management - Planned & Unplanned Time Away policy dated August 1, 2021, indicated:<br>"For unplanned resident time away when a pharmacist or licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if:<br>1. The registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents.<br>2. The registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are | 0 650 | | |

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| 0 650 | Continued From page 13<br><br>prescribed for the resident. The procedures must address:<br>a. the type of container or containers to be used for the medications appropriate to the provider's medication system<br>b. how the container or containers must be labeled<br>c. the written information about the medications to be given to the resident or resident's representative<br>d. how the unlicensed staff must document in the resident's record that medications have been given to the resident or the resident's representative, including documenting the date the medications were given to the resident or the resident's representative and who received the medications, the person who gave the medications to the resident, the number of medications that were given to the resident, and other required information<br>e. how the registered nurse shall be notified that medications have been given to the resident or resident's representative and whether the registered nurse needs to be contacted before the medications are given to the resident or the resident's representative<br>f. a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel<br>g. how the unlicensed staff must document in the resident's record any unused mediations that are returned to the provider, including the name of each medication and the doses of each returned medication."<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 650 | | |

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| 0 660 SS=F | 144G.42 Subd. 9 Tuberculosis prevention and control<br><br>(a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines.<br>(b) The facility must maintain written evidence of compliance with this subdivision.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure tuberculosis (TB) symptom screening and testing was completed at the time of hire for one of two employees (registered nurse (RN)-E).<br><br>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).<br><br>The findings include:<br><br>The licensee's TB Risk Assessment was | 0 660 | | |

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| 0 660 | Continued From page 15<br><br>completed on November 13, 2023, and indicated the facility was at a low risk for TB transmission.<br><br>RN-E was hired on May 17, 2023, to provided direct cares to residents and oversite to unlicensed personnel (ULP).<br><br>On November 15, 2023, at 1:27 p.m., the surveyor observed RN-E reviewing medication pillbox setups for R1, R2 and R3 with ULP-B.<br><br>On November 15, 2023, at 9:37 a.m., licensed assisted living director (LALD)-D stated they did not have TB test results or TB screening documentation for RN-E. LALD-D stated they were in communication with RN-E to see if they had testing or screening results they could provide for the surveyor.<br><br>RN-E's QuantiFERON TB Gold Plus test result form indicated RN-E's blood sample was collected on March 14, 2022, with a negative result. The test was not completed within 90-days prior to the date of RN-E's hire as required. The test results were provided to LALD-D by RN-E during the survey.<br><br>RN-E's TB Screening Tool for Health Care Workers form dated May 27, 2023, indicated a TB symptom screening had been completed however it was not signed or dated by RN-E or the staff member who conducted the screening. The screening was provided to LALD-D by RN-E during survey.<br><br>On November 15, 2023, at 10:07 a.m., LALD-D provided RN-E's TB Gold Test results and TB screening documentation which LALD-D stated was provided to them by RN-E on November 15, 2023. LALD-D stated they were unaware of the | 0 660 | | |

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| 0 660 | Continued From page 16<br><br>requirement for TB testing to be completed within 90-days prior to the date of hire. The surveyor showed LALD-D the TB screening form for RN-E which lacked signatures, LALD-D stated, "I agree with you," acknowledging it was incomplete.<br><br>On November 15, 2023, at 10:37 a.m., owner (O)-F stated they were unaware TB testing was required to be completed within 90-days prior to the date of hire for RN-E. O-F stated RN-E was an independently contracted nurse who contracted themselves out and completed their own TB testing and screening. O-F stated RN-E was employed by the licensee.<br><br>The CDC Tuberculosis Screening, Testing, and Treatment of U.S. Health Care Personnel dated May 17, 2019, indicated all health personnel should have a baseline screening and an individual risk assessment, which is necessary for interpreting any test result.<br><br>The Minnesota Department of Health TB FAQ indicated a TB test should be dated within 90 days of the date of hire.<br><br>The licensee's 8.16 Tuberculosis Screening policy dated August 1, 2021, indicated, "Staff whose essential job functions require work within the same air space of home care clients will be screened and tested for tuberculosis prior to the staff being exposed to clients. Baseline (upon hire) screening will be completed, but serial (annual) screening will only be required with increased occupational risk or exposure."<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 660 | | |

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| 0 680 SS=F | 144G.42 Subd. 10 Disaster planning and emergency preparedness<br><br>(a) The facility must meet the following requirements:<br>(1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency;<br>(2) post an emergency disaster plan prominently;<br>(3) provide building emergency exit diagrams to all residents;<br>(4) post emergency exit diagrams on each floor; and<br>(5) have a written policy and procedure regarding missing residents.<br>(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.<br>(c) The facility must meet any additional requirements adopted in rule.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to prominently display a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all residents, staff, and visitors.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a | 0 680 | | |

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| 0 680 | Continued From page 18<br><br>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).<br><br>The findings include:<br><br>The licensee's Emergency Preparedness Manual was last revised on October 30, 2023.<br><br>On November 13, 2023, at 10:15 a.m., licensed assisted living director (LALD)-D and owner (O)-F stated they were familiar with the current minimum assisted living requirements.<br><br>On November 13, 2023, at 11:15 a.m., during the facility tour, the surveyor observed the facility's interior which lacked a prominently displayed EPP or signage which indicated where the EPP could be located. O-F stated they had an EPP which was stored in the downstairs office and was not prominently posted or available for staff and residents.<br><br>On November 13, 2023, at 11:35 a.m., the surveyor observed the EPP located in the downstairs office.<br><br>The licensee's Emergency Preparedness policy dated December 6, 2022, indicated:<br>"10. The Emergency Disaster Plan is prominently posted on each floor of the facility and includes:<br>a. A schematic plan of the facility or portions of the facility that shows<br>i. Evacuation routes<br>ii. As applicable, smoke stop and fire doors<br>iii. Emergency exit diagrams<br>iv. Exit doors | 0 680 | | |

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| 0 680 | Continued From page 19<br>v. If applicable, the location of the fire extinguishers and fire-alarm boxes<br>b. A facility must provide a copy of its plan to a resident or resident representative if requested.<br>11. The Evacuation Plan is posted on each floor of each residence and a copy is provided to all residents on admission.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 680 | | |
| 0 730 SS=D | 144G.43 Subd. 3 Contents of resident record<br><br>Contents of a resident record include the following for each resident:<br>(1) identifying information, including the resident's name, date of birth, address, and telephone number;<br>(2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative;<br>(3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known;<br>(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;<br>(5) the resident's advance directives, if any;<br>(6) copies of any health care directives, guardianships, powers of attorney, or conservatorships;<br>(7) the facility's current and previous assessments and service plans;<br>(8) all records of communications pertinent to the resident's services; | 0 730 | | |

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| 0 730 | Continued From page 20<br><br>(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;<br>(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;<br>(11) documentation that services have been provided as identified in the service plan;<br>(12) documentation that the resident has received and reviewed the assisted living bill of rights;<br>(13) documentation of complaints received and any resolution;<br>(14) a discharge summary, including service termination notice and related documentation, when applicable; and<br>(15) other documentation required under this chapter and relevant to the resident's services or status.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to provide a discharge summary with required content for one of one resident (R1) discharged from the licensee.<br><br>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).<br><br>The findings include: | 0 730 | | |

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| 0 730 | Continued From page 21<br><br>R1 was admitted to the licensee on June 3, 2023, and discharged from the licensee on June 5, 2023.<br><br>R1's Discharge-Transfer Summary lacked the following required information:<br>-a summary of the resident's stay that included diagnoses, courses of illnesses, allergies, treatments and therapies, and pertinent lab, radiology, and consultation results;<br>-a final summary of the resident's status from the latest assessment or review under Minnesota Statutes, section 144G.70, if applicable, that includes the resident status, including baseline and current mental, behavioral, and functional status;<br>-a reconciliation of all predischarge medications with the resident's post discharge prescribed and over-the-counter medications; and<br>-a post discharge plan that is developed with the resident and, with the resident's consent, the resident's representatives, which will help the resident adjust to a new living environment. The post discharge plan must indicate where the resident plans to reside, any arrangements that have been made for the resident's follow-up care, and any post discharge medical and nonmedical services the resident will need.<br><br>On November 14, 2023, at 1:35 p.m., administrator (A)-C acknowledged R1's discharge summary lacked identification of who completed it and when it was completed. A-C stated registered nurse (RN)-G, their former nurse, was the nurse who worked during the time of R1's discharge and was pretty sure they completed the discharge summary.<br><br>On November 15, 2023, at 1:55 p.m., owner | 0 730 | | |

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| 0 730 | Continued From page 22<br><br>(O)-F stated they were present at the time of R1's discharge which was due to R1's behavior and property destruction. (O)-F stated they were unsure if a service termination notice was completed for R1's discharge due to the sudden and unexpected discharge circumstances. They stated they did not have service termination documents to provide.<br><br>The Licensee's 2.38 Resident Record-Information Content policy dated August 1, 2021 indicated: "14. A discharge summary, including service termination notice and related documentation, when applicable."<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 730 | | |
| 0 790 SS=F | 144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment<br><br>(2) install and maintain portable fire extinguishers in accordance with the State Fire Code;<br><br>(3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and<br><br>This MN Requirement is not met as evidenced by: | 0 790 | | |

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| 0 790 | Continued From page 23<br><br>Based on observation and interview, the licensee failed to perform the required annual and monthly maintenance on fire extinguishers. This had the potential to affect all current residents, staff, and visitors.<br><br>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).<br><br>The findings include:<br><br>On November 13, 2023, at 1:50 p.m., survey staff toured the facility with licensed assisted living director in residency (LALD)-D. During the facility tour, it was observed the fire extinguisher did not have a service tag showing it had been inspected annually and lacked records to show the required monthly visual inspections were performed on the portable fire extinguishers.<br><br>On November 13, 2023, at 1:50 p.m., LALD-D verified this deficient condition.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 790 | | |
| 0 810 SS=F | 144G.45 Subd. 2 (b)-(f) Fire protection and physical environment<br><br>(b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: | 0 810 | | |

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| 0 810 | Continued From page 24<br>(1) location and number of resident sleeping rooms;<br>(2) employee actions to be taken in the event of a fire or similar emergency;<br>(3) fire protection procedures necessary for residents; and<br>(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.<br>(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.<br>(d) Fire safety and evacuation plans shall be readily available at all times within the facility.<br>(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.<br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to develop the fire safety and evacuation plan with required content, provide required training and drills. This had the potential to directly affect all residents, staff, and visitors.<br><br>This practice resulted in a level two violation (a | 0 810 | | |

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| 0 810 | Continued From page 25<br><br>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).<br><br>The findings include:<br><br>On November 14, 2023, licensed assisted living director (LALD)-D and owner (O)-F provided documentation on the fire safety and evacuation plan, fire safety and evacuation training for the facility, and fire safety and evacuation drills for the facility.<br><br>FIRE SAFETY and EVACUATION PLAN<br>Record review of available documentation indicated the facility had provisions for general fire safety in the Emergency Preparedness Plan but did not include facility-specific fire safety procedures and did not address the facility-specific evacuation procedure.<br><br>During the interview on November 14, 2023, at 2:00 p.m., LALD-D stated the policy was from a third-party provider and had yet to be edited or updated to fit the facility. LALD-D verified the fire safety and evacuation plan for the facility lacked these provisions.<br><br>TRAINING<br>Record review of the available documentation indicated employees did not receive training twice per year after initial hire.<br><br>During the interview on November 14, 2023, at 2:00 p.m., LALD-D stated the licensee provided | 0 810 | | |

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| 0 810 | Continued From page 26<br><br>annual training to employees, but not twice per year after the initial hire, on the fire safety and evacuation plan, as required by statute.<br><br>DRILLS<br>Record review of the available documentation indicated the licensee did not conduct evacuation drills twice per year per shift and every other month as required by statute. Provided documentation indicated drills were conducted on 11/27/22 at 1:00 p.m., 2/22/23 at 11:33 a.m., 5/16/23 at 4: 30 p.m., with no further fire drills being documented. Review of the provided drill documentation also indicated the licensee conducted shelter-in-place drills on 9/26/23, 10/26/23 however the conducted drills did not incorporate evacuation procedures to qualify as an evacuation drill.<br><br>During the interview on November 14, 2023, at 2:00 p.m., LALD-D statedthere were no further documented drills for the facility and verified this deficient condition.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 810 | | |
| 0 820 SS=I | 144G.45 Subd. 2 (g) Fire protection and physical environment<br><br>(g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the | 0 820 | | |

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| 0 820 | Continued From page 27<br><br>facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide resident bedrooms with the minimum window opening meeting the minimum state standard for egress. This had the potential to directly affect all residents. This affected the occupied resident bedrooms #1 and #3 on the main level.<br><br>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).<br><br>The findings include:<br><br>On November 13, 2023, at 1:50 p.m., survey staff toured the facility with the Licensed Assisted Living Director in Residency (LALD)-D. During the facility tour, survey staff observed the following items:<br><br>It was observed that occupied resident bedroom #3 on the main level did not have windows that met the minimum size requirements for egress escape. The clear openable area of the opened | 0 820 | This immediate correction order identified on November 13, 2023, has had the immediacy lifted as of November 14, 2023, by assigning a fire watch for the facility. This was confirmed by the licensee via email and approved by evaluation supervisor. | |

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| 0 820 | Continued From page 28<br><br>windows measured 14 inches in height and 39.5 inches in width, with a total openable area of 553 square inches. The windows did not meet the minimum requirements for opening height and did not meet the minimum requirements for total openable area.<br><br>It was observed that unoccupied resident bedroom #1 on the main level did not have windows that met the minimum size requirements for egress escape. The clear openable area of the opened windows measured 16.5 inches in height and 40 inches in width, with a total openable area of 660 square inches. The windows did not meet the minimum requirements for opening height.<br><br>Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. Survey staff explained to LALD-D that at least one egress window in each bedroom must be provided to meet the minimum state standard for an egress window to be a complying bedroom for resident occupancy. LALD-D verbally confirmed the findings.<br><br>On November 13, 2023, at 3:20 p.m., during the phone interview, survey staff explained to LALD-D that an immediate correction order was issued for the above finding. LALD-D acknowledged the above finding.<br><br>No Further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Immediate. | 0 820 | | |

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| 0 970 | Continued From page 29 | 0 970 | | |
| 0 970 SS=C | 144G.50 Subd. 5 Waivers of liability prohibited<br><br>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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal property for two of two residents (R2, R3).<br><br>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).<br><br>The findings include:<br><br>R2 and R3's record each included a contract with different contract formats and different waiver of liability statements, neither contract indicated when they were last revised.<br><br>R2's record included an Assisted Living Agreement (contract) signed on March 23, 2023, which included the following waivers of liability:<br>"9. Insurance: | 0 970 | | |

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| 0 970 | Continued From page 30<br>a. Each resident should maintain his or her own health, personal property, liability and other applicable insurance policies.<br>b. Cosmo Home Health Care Services does not provide insurance for you or your property.<br>1. Insurance Liability and Release. The resident shall maintain at all times his or her own health, personal property, liability, automobile (if applicable), and other insurance coverages and shall provide evidence of same by copies of binders or policies provided to Cosmo Home Health Care Services upon request. The resident acknowledges that Cosmo Home Health Care Services is not an insurer of the resident's person or property. The resident agrees that Cosmo Home Health Care Services will not be liable to the resident for any personal injury or property damage (including, without limitation, damage to, or loss or theft of, automobiles or personal property of resident) suffered by the resident or the resident's agents, guests or invitees, unless and to the extent that the injury or damage is caused by the negligence of Cosmo Home Health Care Services or its employees or agents. The resident hereby releases Cosmo Home Health Care Services from liability for any personal injury or property damage suffered by the resident or the resident's agents, guests, or invitees, unless caused by the negligence of Cosmo Home Health Care Services or its employees or agents.<br>Indemnification: Cosmo Home Health Care Services shall not be liable for any damage or injury to the resident, or any other person, or to any property, occurring on the premises, or any Part thereof, or in common areas thereof, and the resident agrees to hold Cosmo Home Health Care Services harmless from any claims or damages unless caused solely by negligence of Cosmo Home Health Care Services. It is recommended that renter's insurance be | 0 970 | | |

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| 0 970 | Continued From page 31<br>purchased at the resident's expense. Nothing contained herein is intended to create a waiver of facility liability for the health and safety or personal property of a resident."<br><br>R3's record included an Assisted Living Agreement signed on October 31, 2023, which included the following waivers of liability:<br>"7. Security/valuables/Keys:<br>d. All resident rooms do have security locks. If you choose not to lock your valuables you assume liability for them<br>1. Insurance Liability and Release. The resident shall maintain at all times his or her own health, personal property, liability, automobile (if applicable), and other insurance coverages and shall provide evidence of same by copies of binders or policies provided to COSMO HOME HEALTHCARE SERVICES LLC upon request. The resident acknowledges that COSMO HOME HEALTHCARE SERVICES LLC is not an insurer of the resident's person or property. The resident agrees that COSMO HOME HEALTHCARE SEHVICES LLC will not be liable to the resident for any personal injury or property damage (including, without limitation, damage to, or loss or theft of, automobiles or personal property of resident) suffered by the resident or the resident's agents, guests or invitees, unless and to the extent that the injury or damage is caused by the negligence of COSMO HOME HEALTHCARE SERVICES LLC or its employees or agents. The resident hereby releases COSMO HOME HEALTHCARE SERVICES LLC from liability for any personal injury or property damage suffered by the resident or the resident's agents, guests, or invitees, unless caused by the negligence of COSMO HOME HEALTHCARE SERVICES LLC or its employees or agents.<br>Indemnification: COSMO HOME HEALTHCARE | 0 970 | | |

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| 0 970 | Continued From page 32<br><br>SERVICES LLC shall not be liable for any damage or injury to the resident, or any other person, or to any property, occurring on the premises, or any part thereof, or in common areas thereof, and the resident agrees to hold COSMO HOME HEALTHCARE SERVICES LLC harmless from any claims or damages unless caused solely by negligence of COSMO HOME HEALTHCARE SERVICES LLC. It is recommended that renter's insurance be purchased at the resident's expense. Nothing contained herein is intended to create a waiver of facility liability for the health and safety or personal property of a resident."<br><br>On November 11, 2023, at 1:55 p.m., The licensed assisted living director (LALD)-A acknowledged R2 and R3's contracts included waivers of liability and stated the new updated Assisted Living Agreement had the waivers removed. The surveyor requested the blank copy of the new assisted living agreement. LALD stated they would email the form, but the surveyor received no email correspondence containing a new assisted living agreement.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 970 | | |
| 01130 SS=G | 144G.55 Subd. 2 Safe location<br><br>A safe location is not a private home where the occupant is unwilling or unable to care for the resident, a homeless shelter, a hotel, or a motel. A facility may not terminate a resident's housing or services if the resident will, as the result of the termination, become homeless, as that term is | 01130 | | |

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| 01130 | Continued From page 33<br><br>defined in section 116L.361, subdivision 5, or if an adequate and safe discharge location or adequate and needed service provider has not been identified. This subdivision does not preclude a resident from declining to move to the location the facility identifies.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure a safe discharge location was determined and identified prior to discharge for one of one discharged resident (R1).<br><br>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 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).<br><br>The findings include:<br><br>R1 was admitted to the licensee on June 3, 2023, and discharged from the licensee on June 5, 2023.<br><br>R1's Discharge-Transfer Summary dated as printed November 14, 2023, indicated R1 was admitted to the licensee from RADIAS Health (a non-profit Mental Health & Substance Use Disorder services organization). R1's reason for discharge from the licensee was documented as, "Did not move into Assisted Living." It further indicated R1's discharge location was to, "Client could not be placed into the facility." The | 01130 | | |

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| 01130 | Continued From page 34<br><br>summary lacked a description of the discharge, the circumstances leading up to the discharge, the resident's condition at discharge, and by whom and when the discharge summary was completed. The summary had a space for R1's physician information and diagnoses information, which were both left blank. It indicated R1 was scheduled to receive the following services from the licensee: bathing assistance three times per week, bathing reminder three times per week, dressing assistance two times daily, grooming two times daily, meal reminders five times daily, and a morning wake-up daily. It indicated R1 took buprenorphine 2 milligrams (mg) two times daily for withdrawals, gabapentin 300mg three times daily for pain, mirtazapine 7.5mg daily as needed for sleep, and nicotine gum 2mg every one hour as needed for nicotine cravings.<br><br>R1's Medication Admin (administration) Summary dated June 2023, indicated the licensee's staff administered the following to R1:<br>-buprenorphine give two tablets (4mg) under the tongue two times a day, it was administered on June 5, 2023, at 8:00 a.m., and initialed by staff as, "Has been given";<br>-gabapentin 300mg give one tablet by mouth three times a day, it was administered on June 4, 2023, at 12:00 p.m., and June 5, 2023, at 8:00 a.m., and initialed by staff as, "Has been given"; and June 5, 2023, at 12:00 p.m., initialed by staff as administered.<br><br>R1's record lacked a medication disposition for their June 5, 2023, discharge.<br><br>R1's Resident Notes (progress notes) included a single note entered by unlicensed personnel (ULP)-B on June 5, 2023, at 2:52 p.m., which indicated, "The client awoke this morning very | 01130 | | |

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| 01130 | Continued From page 35<br><br>early and was upset. The staff spoke with the client. After taking her morning medications, the client didn't feel well mentally and was aggressive, shouting and screaming in her room while using foul language toward the staff. When the manager arrived to calm the client down, the client felt relieved and thanked him. They had a conversation about her poor behavior and the manager apologized. The client consumed a sandwich, eggs, and coffee before going to her room to nap. Client finally took a nap around 1pm. One hour later client left."<br><br>On June 6, 2023, at 8:44 a.m., owner (O)-F's email to R1's case manager (CM)-H indicated, "Hi [CM-H]. We would like to let you know that we are no longer interested to proceed with [R1's] SA services, because of property distraction (sic) and verbal abuse to the residents and staff. She moved out yesterday due to her behavior. Thank you for your time and consideration. [O-F]. "<br><br>On November 14, 2023, at 1:15p.m., unlicensed personal (ULP-B) stated the licensee had not received R1's medication upon admission, and R1 did not get their medication the day of admission. On June 5, 2023, ULP-B observed R1 pacing, aggressive, physical, and verbally abusive. ULP-B stated they returned for their 3:00 p.m. shift on June 6, 2023, and R1 was gone. ULP-B stated the previous shift stated 911 was called and R1 was discharged due to property destruction.<br><br>On November 14, 2023, at 1:35 p.m., administrator (A)-C stated R1 was only at the facility for one to two days. When R1 was admitted to the licensee everything was okay, but at night R1 became very aggressive and verbally abuse toward staff on June 3, 2023. A-C stated | 01130 | | |

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| 01130 | Continued From page 36<br><br>they had to call the police on June 5, 2023, and the police told R1 they had to leave due to R1's behavior. The surveyor inquired where R1 was expected to go without discharge planning, A-C stated most likely a homeless shelter or RADIAS Health. A-C stated they were later able to confirm R1 had gone to RADIAS Health sometime after they were discharged. A-C stated they did not file a Minnesota Adult Abuse Reporting Center (MAARC) report or notify the ombudsman. A-C stated R1's case manager (CM-H) was notified by O-F via email. A-C acknowledged R1 was discharged without a safe plan or a discharge location and stated everything happened so fast due to the circumstance with R1's behaviors. A-C stated they did not complete an emergency relocation form for R1.<br><br>On November 15, 2023, at 1:55 p.m., O-F stated they were present at the time of R1's discharge on June 5, 2023. They stated the discharge was due to R1's behavior and property destruction. O-F stated they had to call 911 and the police told R1 they had to leave the facility. O-F stated they did not complete a MAARC report or contact the ombudsman but did contact R1's case manager. O-F stated they did not think a MAARC report needed to be filed or to contact the ombudsman. O-F stated they were unsure if a service termination notice was completed but likely not due to the circumstances and everything happening so fast. O-F stated they were unable to say if R1 was safely discharged from their facility to a safe location. O-F stated they sent R1's medications with them, but they did not document the medication disposition. O-F stated they did not have further documentation to provide regarding R1's discharge.<br><br>On November 22, 2023, at 11:19 a.m., the | 01130 | | |

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| 01130 | Continued From page 37<br><br>surveyor received an email response from CM-H which indicated, "Unfortunately, I won't be able to help you with the survey because the case has been closed for a while, and I am no longer working with [R1]."<br><br>The licensee's Discharge and Transfer of Resident policy dated April 22, 2022, indicated: "Policy Statement: Residents discharged or transferred from Cosmo Home Health Services will have a coordinated process for discharge or transition to another provider/setting.<br>Procedure: Facility-Initiated Termination<br>4. Prior to issuing a notice of termination, Cosmo Home Health Services shall schedule and participate in a pretermination meeting with the resident, the resident's legal representative and the resident's designated representative to discuss the reason(s) for the proposed termination and identify/offer reasonable accommodations, modifications or other alternatives to avoid the termination."<br><br>TIME PERIOD TO CORRECT: Seven (7) days | 01130 | | |
| 01620 SS=D | 144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring<br><br>(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.<br>(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 | 01620 | | |

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| 01620 | Continued From page 38<br><br>and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review.<br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted a 14-day assessment no more than 14-calendar days after initiation of services for one of two residents (R2)<br><br>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).<br><br>The findings include:<br><br>R2 was admitted to the licensee on March 23, 2023.<br><br>R2's Service Plan dated March 23, 2023, indicated R2 received services for bathing reminders, grooming, laundry, housekeeping, | 01620 | | |

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| 01620 | Continued From page 39<br><br>behavior management, and medication management.<br><br>R2's record included an admission assessment dated March 23, 2023, and a 14-day registered nurse (RN) assessment completed on April 9, 2023. The 14-day assessment was three days past the 14-calendar day requirement.<br><br>On November 15, 2023, at 1:55 p.m., clinical nurse supervisor (CNS)-A stated they were aware of the 14-day assessment requirement but was not working for the licensee when R2's assessment 14-day assessment was completed. CNS-A stated RN-G completed the assessments and was no longer employed with the licensee.<br><br>The licensee's Assessment and Reassessment policy dated December 6, 2022, indicated, "The RN will provide a reassessment visit to update the evaluation of the resident and services no more than 14 days after initiation of services."<br><br>No additional information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01620 | | |
| 01760 SS=F | 144G.71 Subd. 8 Documentation of administration of medication<br><br>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 | 01760 | | |

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| 01760 | Continued From page 40<br><br>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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to accurately setup medications, transcribe medication orders, and document medication administration for one of two residents (R3).<br><br>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).<br><br>The findings include:<br><br>R3's Service Plan dated October 31, 2023, indicated R3 received medication management services.<br><br>R3's After Visit Summary (AVS) signed and dated by R3's medical provider on October 31, 2023, indicated R3 had the following medication orders:<br>- acetaminophen 325 mg tablet. Take two tablets (650 mg) by mouth every four hours as needed (PRN) for moderate pain or mild pain;<br>- atorvastatin 20 mg tablet. Take one tablet (20 mg) by mouth at bedtime;<br>- Cholecalciferol 1000 units (u) tablet. Take one tablet (1,000u) by mouth daily; | 01760 | | |

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| 01760 | Continued From page 41<br>- citalopram 10 mg tablet. Take one tablet (10 mg) by mouth daily. Indications: major depressive disorder;<br>- haloperidol 5 mg tablet. Take one tablet by mouth at bedtime daily PRN for voices;<br>- ibuprofen 600 mg tablet. Take one tablet (600 mg) by mouth 3 times daily PRN for pain;<br>- levothyroxine 75 mcg tablet. Take one tablet (75 mcg) by mouth daily before morning meal;<br>- naltrexone 50 mg tablet. Take one tablet (50 mg) by mouth daily;<br>- pantoprazole 40 mg tablet. Take one tablet (40 mg) by mouth daily;<br>- Prazosin 1 mg Capsule Take three capsules (3 mg) by mouth at bedtime;<br>- Quetiapine 50 mg tablet. Take one tablet (50 mg) by mouth at bedtime. Indications schizophrenia;<br>- Senna-Time 8.6 mg tablet. Take one tablet by mouth daily PRN;<br>- SM Nicotine 14 mg/ 24hr Patch 24 hr. Apply one patch to skin daily. Apply one patch daily to clean, dry skin. Remove old patch before applying a new patch;<br>- SM Nicotine 4 mg Gum. Chew and park one piece (4 mg) by Gum route every one hour PRN for nicotine craving; and<br>- Trazadone 100 mg tablet. Take two tablets (200mg) by mouth at bedtime.<br><br>MEDICATION ORDER AND TRANSCRIPTION<br>R3's medication administration record (MAR) lacked the following ordered medications:<br>- SM Nicotine 14 mg/ 24hr Patch 24 hr daily;<br>- SM Nicotine 4 mg Gum every one hour PRN;<br>- Senna-Time 8.6 mg tablet daily PRN;<br>- acetaminophen 325 mg tablet. Take 2 | 01760 | | |

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| 01760 | Continued From page 42<br><br>tablets every four hours PRN; and<br>- ibuprofen 600 mg tablet three times daily PRN.<br><br>R3's medication closet lacked the following medication supply:<br>- SM Nicotine 4 mg Gum every one hour PRN;<br>- Senna-Time 8.6 mg tablet daily PRN;<br>- acetaminophen 325 mg tablet. Take 2 tablets every four hours PRN; and<br>- ibuprofen 600 mg tablet three times daily PRN.<br><br>MEDICATION SETUP<br>On November 15, 2023, at 9:45 a.m., the surveyor observed R3's pill box with ULP-B which contained the following medications in the AM slot: atorvastatin 20 mg, Citalopram 10 mg, Naltrexone 50 mg, prazosin 1 mg, Quetiapine 50 mg, Trazadone 100 mg and Haldol 5mg. The Afternoon (PM) slot contained: Cholecalciferol 1000 iu, Levothyroxine 75 mcg, Pantoprazole 40 mg, Citalopram 10 mg and Haldol 5mg. When compared with R3's medication orders and MAR it was determined the AM and PM slots were reversed with AM medications in the PM slot, and PM medications in the AM slot. Haldol and citalopram were both setup in the pill box to be administered twice a day, Sunday through Saturday in the AM and PM slot. The above-mentioned prescribers' orders indicated Citalopram was to be administered once daily and Haldol was to be administered one time daily at bedtime PRN.<br><br>DOCUMENTATION<br>R3's MAR for November 1-15, 2023, lacked documentation for daily administration of Haldol. | 01760 | | |

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| 01760 | Continued From page 43<br><br>On November 15, 2023, at 9:45 a.m., the surveyor observed ULP-B navigating R3's MAR in Rtask (charting software). ULP-B was unable to show the surveyor how to document PRN medication administration. They stated they did not administer PRN medications and did not know how to document PRN medication in the MAR.<br><br>On November 15, 2023, at 10:55 a.m., the surveyor observed ULP-B on an audio phone call while moving pills from one slot to another in R3's pill box. ULP-B stated they were on the phone with clinical nurse supervisor (CNS)-A and was trying to correct the medication setup in R3's pill box. Surveyor inquired to CNS-A if they had delegated medication setups to ULP-B. CNS-A stated no they had not, but was going to do a video call with ULP-B to show them what to do since CNS-A was unable to go onsite. CNS-A stated they received a new medication delivery yesterday from the pharmacy and was unsure if someone added more medications to the pill box.<br><br>On November 15, 2023, at 1:27 p.m., the surveyor observed registered nurse (RN)-E going through resident's pill boxes. RN-E stated they were going through the pill boxes and making corrections.<br><br>On November 15, 2023, at 1:40 p.m., CNS-A stated Haldol was being administered daily at bedtime per R3's request. CNS-A stated they were not aware R3 had orders for the above-mentioned medications missing on the MAR and stated, "I will look into it." CNS-A stated ULPs were trained on how to give and document PRNs. CNS-A stated medication setup was done correctly when they did it and they were unable to explain why the medications were in the wrong | 01760 | | |

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| 01760 | Continued From page 44<br>slot.<br><br>On November 15, 2023, 1:55 p.m., ULP-B stated they had given PRN medication in the past but had to call CNS-A and have them walk them through the PRN administration and documentation process via video call.<br><br>The licensee's 7.08 Medication Management-Administration & Setup policy dated August 1, 2021, read:<br>" POLICY: The nursing staff and unlicensed personnel trained to provide medication administration at Cosmo Home Healthcare Services will document any medication administration provided accurately in each resident record. A licensed nurse will correctly and accurately document any medication setup provided.<br>PROCEDURE:<br>1. Documentation of a medication reminder, medication assistance or medication administration will be completed immediately after that task has been performed.<br>2. Medication reminders will be documented on the medication administration record (MAR) by entering the unlicensed personnel (ULP) initials under "medication reminder" and include the full signature and title of the person who provided the medication reminder.<br>3. Assistance with medication and medication administration will be documented on the MAR by entering the ULP's initials under the date and opposite the medication and dose given and include the full signature and title of the person who provided the medication administration.<br>4. For medication reminders or administration, the documentation must include the medication name, dosage, date and time | 01760 | | |

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| 01760 | Continued From page 45<br>administered, and method and route of administration.<br>5. For active assistance with medications from the dosage box system, the ULP will use the MAR for documenting medications given from a dosage box and will refer to the medications profile listing the medication name, dosage, date, and time administered. It will also include the purpose of the medication and any special instructions if applicable.<br>6. The licensed nurse who sets up the medications in the dosage box will observe and monitor the past week's medication administration documentation and compliance and will initial that this has been done. The medication regimen will also be updated and reviewed at the same time of medication set up.<br>7. The licensed nurse who sets up the medications will also be observant of any problems regarding storage of medications.<br>8. A licensed nurse will set up medications in dosage boxes for the resident, usually on a weekly basis, and will make or direct changes between set ups when necessary. ULP will verify medications are set up correctly in the dosage box before administration to the resident by use of the medication profile. If any question of medication accuracy in the dosage box arises, the unlicensed staff will contact the licensed nurse and receive direct instructions on handling any necessary changes at that time, while in direct contact with the nurse.<br>9. ULP will chart in each resident's medication administration record any problems with medication administration, including refusals.<br>10. ULP will also document any 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 | 01760 | | |

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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 |
|---|---|---|---|---|
| 01760 | Continued From page 46<br><br>administered as prescribed and in compliance with the resident's medication management plan.<br>11. If initials are being used on a MAR, then a signature page must be used that includes the person's name, title, signature, and initials located in an accessible place as verification."<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01760 | | |
| 01770 SS=F | 144G.71 Subd. 9 Documentation of medication setup<br><br>Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure documentation of medication setup included all the required content for one of one resident (R3).<br><br>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).<br><br>The findings include: | 01770 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 36196 | A. BUILDING: _____ B. WING _____ | 11/15/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| COSMO HOME HEALTHCARE SERVICES | 3935 5TH AVENUE SOUTH MINNEAPOLIS, MN 55407 |

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|---|---|---|---|---|
| 01770 | Continued From page 47<br><br>R3 was admitted October 29, 2023.<br><br>R3's service plan signed October 31, 2023, indicated R3 received services including assistance with medication management, housekeeping, bathing, activities of daily living (ADLs), meals reminders and behavior management.<br><br>R3's progress note dated November 7, 2023, at 4:59 p.m., written by clinical nurse supervisor (CNS)-A indicated, "Resident continues to display positive attitude at the group home, able to interact well with other clients, medication pill set up done and resident able to adhere to taking her medication as prescribed. Resident alert and oriented, denies having any health concern today. Reported went to work then later went to pick her refilled medication. Resident was taking a nap during the visit and reported to have had a long tiresome day. Medication set up, updated resident to needing more refills for next week box refills. Resident verbalized understanding." The progress note lacked the following required contents:<br>-name of medication;<br>-quantity of dose;<br>-times to be administered; and<br>-route of administration.<br><br>On November 13, 2023, at 10:15 a.m., during the entrance conference, owner (O)-F, licensed assisted living director (LALD)-D and administrator (A)-C stated medications were setup in pillboxes by their registered nurses (RN) for unlicensed personnel (ULP)s to administer to residents.<br><br>On November 15, 2023, at 1:55 p.m., CNS-A stated they setup medications in pillboxes for the | 01770 | | |

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|---|---|---|---|---|
| 01770 | Continued From page 48<br><br>ULPs to administer to the residents and documented medication setups for residents in the progress notes. CNS-A stated they would email a copy of their documentation.<br><br>The licensee's Medication Documentation policy dated December 6, 2022, indicated:<br>"3. Multicultural Care Center [sic] will document medication set up according to the following<br>a. Date of medication setup<br>b. Name of medication<br>c. Quantity of dose<br>d. Times to be administered<br>e. Route of administration<br>f. Name/title of person completing medication setup<br>4. Documentation of medication administration and medication set up will be completed promptly."<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01770 | | |
| 01870 SS=D | 144G.71 Subd. 18 Medications provided by resident or family me<br><br>When the assisted living facility is aware of any medications or dietary supplements that are being used by the resident and are not included in the assessment for medication management services, the staff must advise the registered nurse and document that in the resident record.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the facility failed to ensure that all medications were | 01870 | | |

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| 01870 | Continued From page 49<br><br>included in the assessment for medication management or documented in the resident record for one of two residents (R2).<br><br>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).<br><br>The findings include:<br><br>R2's diagnoses included Schizophrenia, suicidal ideation, learning disabilities, right ankle sprain, substance use disorder, and H. pylori infection.<br><br>R2's Service Plan dated March 23, 2023, indicated R2 required assistance with bathing, dressing grooming, housekeeping, medication administration, behavior management, and safety checks.<br><br>R2's 90-day Assessment dated October 31, 2023, indicated R2 was not able to safely self-administer their own medications and all R2's medications should be locked in the medication cabinet.<br><br>On November 14, 2023, at 9:50 a.m., the surveyor observed the following medications in R2's room which were not included in R2's prescriber orders dated September 28, 2023:<br>- Cetirizine 10mg, from Hennepin County Medical Center (HCMC) Pharmacy;<br>- Docusate sodium 100mg, from Northpoint Health Center Pharmacy; | 01870 | | |

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| 01870 | Continued From page 50<br><br>- Multivitamin one daily women vitamin dietary supplement from Walgreens Pharmacy;<br>- Omeprazole 20mg, from Northpoint Health Center Pharmacy; and<br>- Ondansetron 8mg, from Northpoint Health Center Pharmacy.<br><br>On November 13, 2023, at 10:15 a.m., during the entrance conference, licensed assisted living director (LALD)-D and owner (O)-F stated their resident's medications were provided by Genoa Pharmacy.<br><br>On November 14, 2023, at 9:50 a.m., R2 stated the facility stored and administered their mental health medications. R2 stated they stored and self-administered the above-mentioned medications found in their room.<br><br>On November 14, 2023, at 2:05 p.m., clinical nurse supervisor (CNS)-A stated R2 was not allowed to administer medications on their own. CNS-A stated all of R2's medications should have been stored in the medication cabinet and administered by the staff. CNS-A was not aware R2 had the above-mentioned medications stored in their room.<br><br>On November 15, 2023, at 9:45 a.m., ULP-B stated they did not administer as needed (PRN) medications. They stated residents were told to buy and keep their own PRN medications.<br><br>The licensee's 7.01 Medication Management-Assessment, Monitoring & Reassessment, dated August 1, 2021, indicated: "POLICY: Cosmo Home Healthcare Services will, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber conduct an | 01870 | | |

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| 01870 | Continued From page 51<br><br>assessment to determine what medication management services will be provided and how the services will be provided.<br>PROCEDURE:<br>1) The assessment must be conducted face-to-face with the resident by an RN.<br>2) The assessment must include an identification and review of all medications the resident is known to be taking.<br>3) The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues.<br>4) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. **"diversion of medication" means misuse, theft, or illegal or improper disposition of medications.<br>5) Cosmo Home Healthcare Services will monitor and reassess the resident's medication management services as needed when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually."<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01870 | | |
| 01910 SS=D | 144G.71 Subd. 22 Disposition of medications<br><br>(a) Any current medications being managed by | 01910 | | |

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|---|---|---|---|---|
| 01910 | Continued From page 52<br><br>the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal.<br>(b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances.<br>(c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to provide documentation of disposition of medications for one of one discharged resident (R1).<br><br>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).<br><br>The findings include: | 01910 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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|---|---|---|---|---|
| 01910 | Continued From page 53<br><br>R1 was discharged from the licensee on June 5, 2023.<br><br>R1's Discharge-Transfer Summary dated as printed November 14, 2023, indicated R1 took buprenorphine 2 milligrams (mg) two times daily for withdrawals, gabapentin 300mg three times daily for pain, mirtazapine 7.5mg daily as needed for sleep, and nicotine gum 2mg every one hour as needed for nicotine cravings.<br><br>R1's Medication Admin (administration) Summary dated June 2023, indicated the licensee's staff administered the following to R1:<br>-buprenorphine give two tablets (4mg) under the tongue two times a day, it was administered on June 5, 2023, at 8:00 a.m., and initialed by staff as, "Has been given";<br>-gabapentin 300mg give one tablet by mouth three times a day, it was administered on June 4, 2023, at 12:00 p.m., and June 5, 2023, at 8:00 a.m., and initialed by staff as, "Has been given"; and June 5, 2023, at 12:00 p.m., initialed by staff as administered.<br><br>R1's record lacked evidence of documented disposition of medications for R1 to include: the name of the medication, strength, prescription number if applicable, quantity, to whom the medications were given, date of disposition, and the names of the staff and other individuals involved in the disposition.<br><br>On November 14, 2023, at 1:42 p.m., administrator (A)-C stated owner (O)-F gave R1's medication to R1 upon discharge but did not have the time to document medication disposition.<br><br>On November 15, 2023, at 1:55 p.m., O-F stated they sent R1's medications with them but they did | 01910 | | |

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| 01910 | Continued From page 54<br>not document the medication disposition.<br><br>The licensee's 7.23 Medication Disposal dated August 1, 2021, indicated:<br>"Unused Prescription Drugs:<br>-Current unused medications managed by Cosmo Home Healthcare Services will be returned to the pharmacy for credit, or given to the resident or the resident's representative, when the resident's medications are no longer managed by the facility or the medication has been discontinued by the prescriber.<br>-Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition."<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01910 | | |
| 03090 SS=C | 144.6502, Subd. 8 Notice to Visitors<br><br>(a) A facility must post a sign at each facility entrance accessible to visitors that states:<br>"Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities."<br>(b) The facility is responsible for installing and maintaining the signage required in this subdivision.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee | 03090 | | |

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| 03090 | Continued From page 55<br><br>failed to ensure the required verbatim notice was posted at the facility main entrance to disclose electronic monitoring activity.<br><br>This practice resulted in a level one violation (a violation that has not potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>On November 13, 2023, at 9:50 a.m., the surveyor observed the facility's main entrance which included a sign which indicated cameras were in use but lacked the required verbatim notice on the posting to indicate, "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities."<br><br>On November 13, 2023, at 11:15 a.m., during the entrance tour, licensed assisted living director (LALD)-D and owner (O)-F acknowledged their video monitoring sign lacked the required verbatim language. LALD-D stated they were aware of the requirement and would update their posting immediately.<br><br>The licensee's Cosmo Home Health Services postings policy, undated, indicated:<br>"ELECTRONIC MONITORING:<br>Cosmo will post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." | 03090 | | |

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| 03090 | Continued From page 56<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 03090 | | |

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

Type: Full
Date: *11/13/23*
Time: 13:00:00
Report: 1013231267

# Food and Beverage Establishment Inspection Report



**Location:**
Cosmo Home Healthcare Services
3935 5th Avenue South
Minneapolis, MN55407
Hennepin County, 27

**Establishment Info:**
ID #: 0038154
Risk:
Announced Inspection: No

**License Categories:**

Expires on: / /

**Operator:**

Phone #: 6127355598
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.

**3-500C Microbial Control: date marking**

***3-501.17B*** ***** Priority 2 *****

MN Rule 4626.0400B Mark the refrigerated, ready-to-eat, TCS food prepared and packaged in a processing plant and opened and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded. The date must not exceed the manufacturer's use-by-date.

OPEN PACKAGE OF READY-TO-EAT DELI MEAT WAS STORED IN THE KITCHEN REFRIGERATOR WITHOUT A DATE MARK. DISCUSSED DATE MARKING PROCEDURES AND STAFF DATE MARKED THE FOOD.

*Corrected on Site*

**4-300 Equipment Numbers and Capacities**

***4-302.12A*** ***** Priority 2 *****

MN Rule 4626.0705A Provide a readily accessible food temperature measuring device to ensure attainment and maintenance of food temperatures.

NO FOOD PROBE THERMOMETER WAS AVAILABLE. RAW MEATS AND EGGS ARE COOKED AND TCS FOODS ARE STORED ON-SITE. COMPLY WITH ABOVE RULE. STAFF SENT A PICTURE OF THE NEW THERMOMETER THAT WAS PURCHASED LATER IN THE DAY.

*Corrected on Site*

**4-300 Equipment Numbers and Capacities**

***4-302.13B*** ***** Priority 2 *****

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

HOT WATER SANITIZING DISH MACHINE IS USED TO WASH WARE. NO TEST KIT MEETING THE ABOVE REQUIREMENT WAS AVAILABLE. DISCUSSED DISH MACHINE TESTING.

*Comply By: 11/17/23*

Type: Full
Date: *11/13/23*
Time: 13:00:00
Report: 1013231267
Cosmo Home Healthcare Services

# Food and Beverage Establishment Inspection Report

**Surface and Equipment Sanitizers**

Hot Water: = at 160 Degrees Fahrenheit
Location: Dish machine
Violation Issued: No

**Food and Equipment Temperatures**

Process/Item: Deli meat
Temperature: 40 Degrees Fahrenheit - Location: Refrigerator
Violation Issued: No

Process/Item: Eggs
Temperature: 39 Degrees Fahrenheit - Location: Refrigerator
Violation Issued: No

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

The inspection was completed with the on-site staff and reviewed with MDH Nurse Evaluators J. Keen and D. Mosissa.

The establishment has a residential kitchen and serves food that is prepared that day. The kitchen has wood cabinets, tile floor, painted walls, laminate counter top, and a textured ceiling.

A two basin sink is located in the kitchen. One basin is designated for hand washing.

A residential dish machine is used to wash ware. The dish machine is run on the sanitize cycle.

Discussed hand washing, ware washing, staff illness policy, temperature control, final cook temperatures, cleaning, serving highly susceptible populations, and food handling procedures.

**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 1013231267 of 11/13/23.

Certified Food Protection Manager: Abdulkadir Shire

Certification Number: 110501 Expires: 01/14/25

**Inspection report reviewed with person in charge and emailed.**

Signed: _____
Mohamed Mohamud
Operator

Signed: JM
Jerry Malloy
Sanitarian Supervisor
FPLS Metro
651-201-3998
jerry.malloy@state.mn.us