Electronically Delivered

February 22, 2022

Administrator
The Homestead At Coon Rapids
11372 Robinson Drive Northwest
Coon Rapids, MN 55433

RE: Project Number(s) SL30689015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on January 13, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health 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.

The enclosed State Form documents the state licensing orders. The Department of Health 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 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.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes 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 Department of Health 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 (a)(5)(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, no immediate fines are assessed.

DOCUMENTATION OF ACTION TO COMPLY

Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up surveys. The licensee is not required to submit a plan of correction 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 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 Department of Health within 15 calendar days of the correction order receipt date.

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place

Free from Maltreatment reconsideration requests should addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place

St. Paul, MN 55164-0970 St. Paul, MN 55164-0970

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,

Jess Gallmeier, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-247-0268 Fax: 651-215-9697

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30689	A. BUILDING: _____ B. WING _____	01/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HOMESTEAD AT COON RAPIDS	11372 ROBINSON DRIVE NW COON RAPIDS, MN 55433

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDERS In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL#30689015 On January 11, 2022, through January 13, 2022, 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 39 residents receiving services under the provider's Assisted Living with Dementia Care license.	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 Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 110 SS=F	144G.10 Subdivision 1a Assisted living director license required	0 110		

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0 110	Continued From page 1 Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensed assisted living director (LALD)-D was listed as the Director of Record for the licensee. This had the potential to affect all the licensee's residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: LALD-D started employment with licensee on August 13, 2021. LALD-D obtained an assisted living director license on April 27, 2021. On January 11, 2022, at approximately 10:00 a.m., the Board of Executives for Long-Term Services and Support (BELTSS) indicated LALD-D held a current assisted living director license, but was not listed as Director of Record for the licensee. On January 11, 2022, at approximately 10:30 a.m., LALD-D stated they were the LALD for the	0 110		

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0 110	Continued From page 2 licensee and did not know they needed to be registered as Director of Record for licensee. The licensee lacked a policy to require LALD to register with BELTSS as the Director of Record for the licensee. No further information provided. TIME PERIOD FOR CORRECTION: Two (2) days Corrected while the surveyor was on site on January 13, 2022.	0 110		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record	0 480		

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0 480	Continued From page 3 review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings included: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated January 11, 2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal.	0 580		

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0 580	Continued From page 4 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to implement and maintain a quality management program appropriate to the size of the facility and relevant to the type of services provided. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On January 11, 2022, at approximately 9:55 a.m., during the entrance conference with licensed assisted living director (LALD)-D, administrator (A)-B, and registered nurse (RN)-A, the surveyor requested to review documentation of the licensee's quality management activities. On January 11, 2022, at approximately 9:58 a.m., A-B stated the licensee's management reviewed and discussed "many things," such as mitigating the spread of COVID-19, the proper use of personal protective equipment (PPE), screening of residents and staff, and staffing issues. On January 11, 2022, at approximately 10:00 a.m., A-B acknowledged and verified a lack of any documentation of quality management meetings held or activities they were currently	0 580		

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0 580	Continued From page 5 undertaking. The licensee's MN Assisted Living Home Care Quality Assessment and Assurance Protocol policy, undated, lacked evaluation of the quality of care by periodically reviewing resident services and documenting such quality management activities. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 580		
0 630 SS=F	144G.42 Subd. 6 Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for three of three residents (R1, R2, and R3) with records reviewed. This practice resulted in a level two violation (a	0 630		

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0 630	Continued From page 6	0 630		

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

The findings include:

R1 admitted to licensee on November 7, 2017.

R1's Uniform Nursing Assessment - Homestead at Coon Rapids, dated December 21, 2021, indicated multiple areas of vulnerability and that R1 is considered vulnerable and there are no signs of abuse.

R1's record included an untitled, undated, and unsigned document identified by registered nurse (RN)-A as R1's service plan. The document contained all services R1 received, R1's care plan, and R1's abuse prevention plan. The document indicated vulnerabilities were identified on R1's assessment but lacked specific measures to be taken to reduce the risk of the identified areas of vulnerability.

R2 admitted to licensee on December 12, 2015.

R2's Uniform Nursing Assessment - Homestead at Coon Rapids, dated December 10, 2021, indicated multiple areas of vulnerability and that R2 is considered vulnerable and there are no signs of abuse.

R2's record included an untitled, undated, and unsigned document identified by RN-A as R2's service plan. The document contained all services R2 received, R2's care plan, and R2's

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0 630	Continued From page 7	0 630		

abuse prevention plan. The document indicated vulnerabilities were identified on R2's assessment but lacked specific measures to be taken to reduce the risk of the identified areas of vulnerability.

R3 admitted to licensee on December 16, 2021.

R3's Uniform Nursing Assessment - Homestead at Coon Rapids, dated January 11, 2022, indicated multiple areas of vulnerability and that R3 is considered vulnerable and there are no signs of abuse.

R3's record included an untitled, undated, and unsigned document identified by RN-A as R3's service plan. The document contained all services R3 received, R3's care plan, and R3's abuse prevention plan. The document lacked vulnerabilities identified on R3's assessment and specific measures to be taken to reduce the risk of the identified areas of vulnerability.

On January 13, 2022, at approximately 12:00 p.m., RN-A, administrator (A)-C, licensed assisted living director (LALD)-D, and RN-E acknowledged the IAPPs for the residents lacked specific measures to be taken by the licensee for R1 and R2, additionally R3's lacked identifying areas of vulnerability. RN-A stated all staff are required to review the service plan but acknowledged specific interventions for each resident's vulnerabilities were not included.

The licensee's Resident/Client/Participant Protection/Freedom From Abuse, Neglect and Misappropriation Policy and Procedure, dated March 2021, indicated upon admission and periodically thereafter, each resident will have a vulnerability assessment completed. The

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0 630	Continued From page 8 interdisciplinary team will identify the vulnerabilities on the residents' care plans. The policy lacked the development and implementation of an IAPP for each vulnerable adult. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 650 SS=A	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. (b) Each employee record must be retained for at least three years after a paid employee,	0 650		

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0 650	Continued From page 9 volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure annual performance reviews were completed for one of two employees (registered nurse (RN)-A) with employee records reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On January 12, 2022, at approximately 8:20 a.m., RN-A served residents breakfast in the dining room. RN-A started employment on April 5, 2019, under the comprehensive home care license and began providing assisted living services on August 1, 2021. RN-A's employee record lacked evidence of annual performance reviews. On January 13, 2022, at approximately 12:00 p.m., administrator (A)-C, licensed assisted living director (LALD)-D, and RN-E acknowledged RN-A's employee record lacked annual performance reviews and stated they will update	0 650		

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0 650	Continued From page 10 the record to reflect the required documentation. The licensee's Performance Review Guidelines policy, dated August 7, 2002, and revised July 1, 2012, indicated employees will receive periodic performance reviews. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment of the facility in a continuous state of good repair and operation. This has the potential to directly affect the health, safety, and well-being of all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that	0 800		

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0 800	Continued From page 11 has affected or has the potential to affect a large portion or all of the residents). The findings include: On January 19, 2022, between 1:15 p.m. and 4:00 p.m., survey staff toured the memory care building and the assisting living building with the maintenance assistant (M)-G, the administrator (A)-C, and the licensed assisted living director (LALD)-D. ASSISTED LIVING FACILITY On January 19, 2022, at approximately 2:00 p.m., survey staff toured an unoccupied resident room, D1, and observed plumbing traps of the plumbing fixtures were completely dried out, which would allow sewer gas to enter the building environment creating unsafe, health risks to residents and employees. Survey staff also observed that the handheld showerhead discharged rusty color water due to stagnation and rust, and the bathroom exhaust fan was not properly functioning and producing mechanical noise. On January 19, 2022, at approximately 2:30 p.m., survey staff toured an unoccupied resident room, B1, and observed plumbing traps of the plumbing fixtures were completely dried out, which would allow sewer gas to enter the building environment creating unsafe, health risks to residents and employees. Survey staff also observed a water leak from the toilet. MEMORY CARE BUILDING On January 19, 2022, at approximately 3:40 p.m., while on the tour of the memory care building, survey staff observed the exterior walkways serving the marked exit doors through the courtyards were blocked with snow and not	0 800		

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THE HOMESTEAD AT COON RAPIDS	11372 ROBINSON DRIVE NW COON RAPIDS, MN 55433

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 800	Continued From page 12 maintained for safe means of egress to the roadway. On January 19, 2022, at approximately 3:20 p.m., survey staff toured resident room #5 in the memory care building and observed the toilet was heavily soiled and stained, the toilet paper holder was missing, and so was the toilet paper. BOTH BUILDINGS On January 19, 2022, between 1:30 p.m. to 4:00 p.m., survey staff observed the tags on the reduced pressure zone backflow preventers (RPZs) in the mechanical rooms showed the last date tested was September 11, 2020. RPZ devices must be tested annually by an approved testing company to prevent cross-connection and ensure the proper performance of RPZ devices to protect the building water supply system. On January 19, 2022, at approximately 5:00 p.m., the A-C and the LALD-D acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=E	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency;	0 810		

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0 810	Continued From page 13 (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide all required content on the fire safety and evacuation plan, and the minimum required training of staff and residents on fire and safety evacuation. This has the potential to directly affect the safety of staff and all residents receiving care in the assisted living building and the memory care building. 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	0 810		

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0 810	Continued From page 14 cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On January 19, 2022, at approximately 4:00 p.m., survey staff received the facility fire safety and evacuation plan and related documentation from the administrator (A)-C for review. -The policy documentation lacked the content of training on the fire safety and evacuation plan upon hiring and at least twice per year thereafter. -The policy documentation lacked the content of required annual training of the residents in the assisted living building and any residents in the memory care building that can self-assist in their evacuation on the proper actions to be taken in the event of a fire including movement, evacuation, or relocation. -The documentation lacked fire protection procedures for residents. -Records showed sufficient numbers of evacuation drills have been performed to date by employees, but the policy documentation lacked the content of minimum numbers of required evacuation drills that must be performed by employees twice per year per shift, with at least one evacuation drill every other month. On January 19, 2022, at approximately 5:15 p.m., the A-C and the licensed assisted living director (LALD)-D acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 810		
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs	01440		

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01440	Continued From page 15 (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure direct supervision of staff performing delegated tasks was provided within 30 calendar days after the task was delegated for one of one unlicensed personnel (ULP)-B with record reviewed. 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	01440		

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01440	Continued From page 16 or has the potential to affect a large portion or all of the residents). The findings included: On January 12, 2022, at approximately 7:00 a.m., ULP-B assisted R3 with a blood sugar check and obtained R3's blood glucose level. ULP-B started employment on April 5, 2019, under the comprehensive home care license and began providing assisted living services on August 1, 2021. ULP-B's record lacked documentation of supervision within 30 calendar days after the date the treatment task was delegated to ULP-B. On January 12, 2022, at approximately 8:00 a.m., ULP-B indicated they had been trained to obtained blood glucose readings as part of their orientation. ULP-B stated they complete blood glucose checks for multiple residents. On January 13, 2022, at approximately 12:00 p.m., registered nurse (RN)-A, administrator (A)-C, licensed assisted living director (LALD)-D, and RN-E acknowledged ULP-B's record lacked documentation of supervision by the RN within 30 calendar days from the date the blood glucose treatment task was delegated to ULP-B. RN-A stated the 30 day supervision on each delegated task was completed, but documentation was not included in ULP-B's record. The licensee's, Delegation of Nursing Tasks, Medication Administration, Treatment Administration or Therapy Tasks to Unlicensed Personnel policy, dated August 1, 2021, indicated direct supervision of staff performing delegated tasks will be performed within 30 calendar days	01440		

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01440	Continued From page 17 after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. The policy instructed the RN to document each unlicensed staff person's training and competency to assist or administer medications, treatment and therapy in the personnel record of each staff person who has satisfied the above training and competency requirements. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		
01640 SS=F	144G.70 Subd. 4 Service plan, implementation, and revisions t (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable.	01640		

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01640	Continued From page 18 (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the current service plan included a signature or other authentication by the resident or the resident's representative and the facility to document agreement on the services to be provided for three of three residents (R1, R2, and R3) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 admitted to licensee on November 7, 2017. R1's unsigned and undated service plan indicated R1 was receiving services including oxygen therapy, housekeeping, skin care, toileting, registered nurse (RN) assessments, dressing, bathing, laundry, grooming, mobility assistance, behavior management, treatment and therapy services, medication management, and activities of daily living. R2 admitted to licensee on December 7, 2015. R2's unsigned and undated service plan indicated R2 was receiving services including oxygen	01640		

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01640	Continued From page 19 therapy, continuous positive airway pressure (CPAP) therapy (treatment for sleep apnea), transportation, toileting, dressing, bathing, personal hygiene, mobility services, skin care, activities of daily living, housekeeping, laundry, encourage participation in activities, pain management, treatment and therapy services, and medication management services. R3 admitted to licensee on December 16, 2021. R3's unsigned and undated service plan indicated R3 was receiving services including personal hygiene, mobility services, activities of daily living, housekeeping, laundry, encourage participation in activities, treatment and therapy services, and medication management services. On January 13, 2022, at approximately 9:30 a.m., licensed assisted living director (LALD)-D acknowledged the service plans were not signed, and stated their documentation system updated the service plan at every assessment. LALD-D stated the updates were not acknowledged by the residents by signing the updated service plans. The licensee's Service Plan Development and Content of a Service Plan policy, dated August 1, 2021, indicated each resident will have up-to-date service plan identifying services to be provided based on the RN assessment and will be signed and dated by the resident or resident representative. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		

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01650	Continued From page 20	01650		
01650 SS=F	144G.70 Subd. 4 Service plan, implementation, and revisions t (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan included the required content for three of three residents (R1, R2, and R3) with records reviewed. This practice resulted in a level two violation (a	01650		

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01650	Continued From page 21	01650		

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 the potential to affect a large portion or all of the residents).

The findings include:

R1 admitted to licensee on November 7, 2017.

R1's unsigned and undated service plan indicated R1 was receiving services including oxygen therapy, housekeeping, skin care, toileting, registered nurse (RN) assessments, dressing, bathing, laundry, grooming, mobility assistance, behavior management, treatment and therapy services, medication management, and activities of daily living. R1's service plan lacked the following content:
-the schedule and methods of monitoring assessments of the resident;
-the schedule and methods of monitoring staff providing services;
-a contingency plan that includes: information and a method to contact the facility and the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency.

R2 admitted to licensee on December 7, 2015.

R2's unsigned and undated service plan indicated R2 was receiving services including oxygen therapy, continuous positive airway pressure

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01650	Continued From page 22 (CPAP) therapy (treatment for sleep apnea), transportation, toileting, dressing, bathing, personal hygiene, mobility services, skin care, activities of daily living, housekeeping, laundry, encourage participation in activities, pain management, treatment and therapy services, and medication management services. R2's service plan lacked the following content: -the schedule and methods of monitoring assessments of the resident; -the schedule and methods of monitoring staff providing services; -a contingency plan that includes: information and a method to contact the facility and the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency. R3 admitted to licensee on December 16, 2021. R3's unsigned and undated service plan indicated R3 was receiving services including personal hygiene, mobility services, activities of daily living, housekeeping, laundry, encourage participation in activities, treatment and therapy services, and medication management services. R3's service plan lacked the following content: -the schedule and methods of monitoring assessments of the resident; -the schedule and methods of monitoring staff providing services; -a contingency plan that includes: information and a method to contact the facility and the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and	01650		

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01650	Continued From page 23 information as to who has authority to sign for the resident in an emergency. On January 13, 2022, at approximately 12:15 p.m., licensed assisted living director (LALD)-D acknowledged the service plans were missing required content and stated the licensee will work with their corporate office to update all their residents' service plans. The licensee's Service Plan Development and Content of a Service Plan policy, dated August 1, 2021, indicated all the missing service plan content will be included. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions;	01730		

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01730	Continued From page 24 (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop an individualized medication management record with the required content for three of three residents (R1, R2 and R3) with records reviewed. 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	01730		

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01730	Continued From page 25 or has the potential to affect a large portion or all of the residents). The findings include: On January 12, 2022, at approximately 7:30 a.m., unlicensed personnel (ULP)-B administered medications to R3. On January 12, 2022, at approximately 8:15 a.m., ULP-F administered medications to R1 with a glass of water in her room. On January 12, 2022, at approximately 8:30 a.m., ULP-B administered medications to R2. R1 was admitted to licensee on November 7, 2017. R1's diagnoses included dementia (a group of symptoms that affect memory, thinking and interferes with daily life). R1's unsigned and undated service plan indicated R1 received medication management services. R1's service plan lacked procedures for notifying the registered nurse (RN) or appropriate licensed health professional when a problem arises with medication management and services. R1's prescriber orders, dated September 29, 2021, included: -atorvastatin calcium tablet 20 milligram (mg) give one tablet by mouth one time daily for high cholesterol, -citalopram hydrobromide tablet 20 mg give one tablet by mouth one time daily for depression, -gabapentin capsule 300 mg give one capsule by mouth three times daily for leg pain, -ipratropium-albuterol solution 0.5-2.5 mg/3 milliliter (ml) give 3 ml inhaled every two hours as needed for shortness of breath,	01730		

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-lisinopril tablet 5 mg give one tablet by mouth one time daily for hypertension, and
-oxycodone hcl tablet 5 mg give 2.5 mg tablet two times daily for pain.

R2 admitted to licensee on December 7, 2015. R2's diagnoses included chronic obstructive pulmonary disease (COPD), diabetes mellitus type 2, and chronic kidney disease stage 3.

R2's unsigned and undated service plan, and R2's Client Individualized Medication Management Plan, dated March 1, 2018, indicated R2 received medication management services. The documents lacked procedures for notifying the RN or appropriate licensed health professional when a problem arises with medication management and services.

R2's prescriber orders, dated January 12, 2022, included:
-fluticasone furoate-vilanterol 100-25 microgram (mcg)/inhalation (INH) one puff one time per day for COPD,
-calcium carbonate-vitamin D 600-200 mg/unit (IU) one time per day for supplement,
-Cozaar 100 mg one time per day for hypertension,
-Cymbalta delayed release 120mg one time per day for depression,
-famotidine 10mg one time per day for reflux,
-metoprolol succinate extended release (ER) 50 mg one time per day for hypertension,
-oxybutynin chloride ER 10 mg one time per day for overactive bladder,
-vitamin D3 50 mcg one time per day for supplement,
-acetaminophen 1000mg three times per day for pain, and
-gabapentin 300mg three times per day for pain.

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01730	Continued From page 27 R3 admitted to licensee December 16, 2021. R3's diagnoses included hypertension and diabetes mellitus type 2. R3's unsigned and undated service plan indicated R3 received medication management services. R3's Medication Review Report, dated December 20, 2021, included 26 provider ordered medications to be managed by licensee. R3's Medication Review Report lacked specific resident instructions, tasks that may be delegated, and procedures for notifying the RN or appropriate licensed health professional when a problem arises with medication management and services. On January 13, 2022, at approximately 12:00 p.m., RN-A, administrator (A)-C, licensed assisted living director (LALD)-D, and RN-E acknowledged each resident's medication management plan lacked required content. RN-A stated they thought all the required content was included by licensee; however, RN-A acknowledged some content was missed. RN-A stated that all ULPs were trained to contact the RN for all questions or concerns but was not included in each resident's medication management plan. The licensee's Development of the Individualized Medication Management Plan and Individualized Medication Record policy, dated August 1, 2021, indicated the plan will address identification of any specific resident instructions regarding medications staff will administer; identification of the staff who are responsible for the medication management tasks, including tasks delegated to unlicensed staff; and the procedure for staff to	01730		

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01730	Continued From page 28 notify the licensed nurse there is a problem with any medication management service. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (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; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address:	01790		

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01790	Continued From page 29 (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) developed training and competencies for unlicensed personnel (ULP) providing medications to residents for unplanned time away from home when the licensed nurse was not available for one of one employee, unlicensed personnel (ULP)-B with record reviewed.	01790		

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01790	Continued From page 30 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-B started employment on April 5, 2019, under the comprehensive home care license and began providing assisted living services on August 1, 2021. ULP-B's record lacked documentation of training and competencies for unplanned time away when the RN is not available. On January 13, 2022, at approximately 12:00 p.m., RN-A, administrator (A)-C, licensed assisted living director (LALD)-D, and RN-E acknowledged ULP-B's record lacked documentation for residents' unplanned time away. RN-A stated ULPs contact the on-call RN for residents' unplanned time away. RN-A stated ULPs documentation of competency for residents unplanned time away would not be in any employee records. The licensee's Medications for a Client Who Will be Away from Home When Medications are Scheduled policy, dated March 2018, indicated the RN may delegate this task to ULPs if the RN has trained and competency tested ULPs on procedures to follow when giving medications to clients who will be away from home when medications are scheduled.	01790		

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01790	Continued From page 31 No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by 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. (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. (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. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to dispose of expired medication and document the disposition of expired medication for two of two residents (R5 and R6) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or	01910		

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01910	Continued From page 32	01910		

safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).

The findings include:

R5
On January 12, 2022, at approximately 7:00 a.m., the surveyor observed R5's Saline Nasal Spray Solution with an expiration date of 2019 in the medication storage cart.

R5's Clinical Physician Orders, dated January 12, 2022, listed discontinued medications. The orders also indicated medication was not administered after the medication was expired.

R5's Medication Review Report, dated January 12, 2022, did not include a current order for Saline Nasal Spray Solution.

On January 12, 2022, at approximately 7:00 a.m., unlicensed personal (ULP)-B stated they are not sure why the expired medication is in the medication cart, but it should be removed as that medication is no longer used.

On January 12, 2022, at approximately 7:30 a.m., registered nurse (RN)-A stated they go through the medication cart one to two times a week and was not sure how the medication was missed so long.

On January 13, 2022, at approximately 12:00 p.m., RN-A, administrator (A)-C, licensed assisted living director (LALD)-D, and RN-E

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01910	Continued From page 33	01910		

acknowledged the presence of the expired medication in the medication cart. RN-A stated it should have been removed at the time the medication was discontinued and documented on their disposition of medications sheet for R5.

R6
On January 12, 2022, at approximately 7:30 a.m., ULP-F administered medications to R6.

R6's physician orders, signed and dated January 5, 2022, indicated the following prescriptions:
-aspirin tablet 81 milligram (mg) take one tablet by mouth one time a day for heart health,
-losartan potassium tablet 100 mg take one tablet by mouth daily for hypertension,
-senna plus tablet 8.6-50 mg take one tablet by mouth as needed daily for constipation, and
-seroquel tablet 25 mg take one tablet by mouth every 12 hours as needed for severe agitation.

On January 12, 2022, at approximately 8:20 a.m., the surveyor observed the contents of R6's medication box and noted the following expired medications:
-senna-s 8.6-50 milligram (mg), four packets past manufacturer's use by dates of April 2020, August 1, 2020, April 24, 2021, and November 16, 2021.
-calcium antacid 300 mg, one packet past manufacturer's use by date of December 2019.

On January 12, 2022, at approximately 8:50 a.m., RN-A acknowledged R6's medication box had medications beyond the manufacturer's use by date, and stated the nurse checked each resident's medications weekly, but did not understand how they missed pulling them out.

The licensee's Omnicare, a CVS Health Company, 5.3 Storage and Expiration Dating of

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01910	Continued From page 34 Medications, Biologicals policy, dated December 1, 2021, read the licensee should ensure that medications and biologicals that have an expired date on the label; have been retained longer than recommended by manufacturer or supplier guidelines; or have been contaminated or deteriorated, are stored separate from other medications until destroyed or returned to the pharmacy or supplier. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
01940 SS=F	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and	01940		

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01940	Continued From page 35 (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a current individualized treatment management record was developed to include the required content for three of three residents (R1, R2, and R3) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1, R2, and R3's records lacked a current individualized treatment management record that included documentation of specific resident instructions and identification of treatment tasks that would be delegated to unlicensed personnel (ULP). R1, R2, and R3's records included an untitled, undated, and unsigned document identified by registered nurse (RN)-A as the "service plan,"	01940		

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01940	Continued From page 36 contained all services R3 received, the care plan, Nurse To do list, and treatment management plan in one document. R1 admitted to the licensee on November 7, 2017. R1's Uniform Nursing Assessment - Homestead at Coon Rapids, dated December 21, 2021, indicated R1 received the following treatments: Voltaren Gel 1% (pain reducing gel medication), change oxygen tubing every week, and specific resident instructions would be included on a seperate document titled Nurse To do list. R1's Nurse To do list, dated October 1, 2021, lacked documentation of specific resident instructions related to the treatment administration and tasks that would be delegated to the ULPs. R2 admitted to the licensee on December 12, 2015. R2's Uniform Nursing Assessment - Homestead at Coon Rapids dated December 10, 2021, indicated R2 received the following treatments: knee high TEDS (thomboletic stockings or socks) on in the morning, off at bedtime, and lotion to legs and feet as needed at bedtime and specific resident instruction would be included on a seperate document titled Nurse To do list. R2's Nurse To do list, dated September 23, 2021, lacked documentation of specific resident instructions related to the treatment administration and tasks that would be delegated to the ULPs. R3 admitted to the licensee on December 16,	01940		

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01940	Continued From page 37 2021. R3's Uniform Nursing Assessment - Homestead at Coon Rapids dated January 11, 2022, indicated R3 received Accu Checks (blood glucose monitoring) and specific resident instruction would be included on a seperate document titled Nurse To do list. R3's Nurse To do list, dated December 16, 2021, lacked documentation of specific resident instructions related to the treatment administration and tasks that would be delegated to the ULPs. On January 13, 2022, at approximately 12:00 p.m., registered nurse (RN)-A, administrator (A)-C, licensed assisted living director (LALD)-D, and RN-E acknowledged residents' treatment and therapy management plans lacked specific resident instruction and tasks that would be delegated to the ULPs. RN-E stated all ULPs are trained specifically to each resident's treatments, but documentation of instructions would not be included in the treatment plans. The licensee's Development of the Treatment and Therapy Services and Individualized Treatment and Therapy Record policy, dated August 1, 2021, indicated the plan will include documentation of specific resident instructions relating to treatments or therapy administration and identification of treatment or therapy tasks that will be delegated to ULPs. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		

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01970	Continued From page 38	01970		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure written or electronically recorded prescriptions were obtained for one of three residents (R1) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted to licensee on November 7, 2017. R1's diagnoses included chronic obstructive pulmonary disease (COPD), chronic respiratory failure with hypoxia, and pneumonia. R1's medication administration record (MAR),	01970		

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01970	Continued From page 39 dated January 2022, indicated R1 received once per day oxygen saturation check and weekly oxygen tubing change, which was initialed as completed on January 1, 2022, and January 8, 2022. R1's undated and unsigned service plan indicated R1 began receiving oxygen therapy on December 6, 2018. R1's prescriber orders, titled Medication Review Report, dated September 29, 2021, lacked oxygen as a prescriber's order. R1's unsigned after-visit summary, dated October 26, 2021, indicated R1 received home oxygen use continuously at two liters per minute at rest, and three liters per minute with activity, per nasal cannula. On January 13, 2022, at approximately 12:00 p.m., registered nurse (RN)-A acknowledged R1's record lacked a signed physician order for home oxygen therapy and stated she will contact the provider to sign the order. The licensee's policy for prescrber orders was requested but was not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the	02040		

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02040	Continued From page 40 requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on observation, document review, and interview, the licensee failed to provide a complete facility hazard vulnerability or safety risk assessment (HVA) plan to identify hazard vulnerabilities and mitigations on and around the property. The hazards identified on the HVA plan must be mitigated to protect the dementia care residents from harm. This has the potential to directly affect all residents in the memory care building receiving assisted living services. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the clients). The findings include: On January 19, 2022, at approximately 4:00 pm, survey staff received the HVA documentation, Kaiser Permanente Risk Assessment, from the administrator (A)-C for review.	02040		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30689	A. BUILDING: _____ B. WING _____	01/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HOMESTEAD AT COON RAPIDS	11372 ROBINSON DRIVE NW COON RAPIDS, MN 55433

(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
02040	Continued From page 41 - The HVA plan lacked specific hazard assessment content on and around the property to protect the dementia care residents from harm. Hazard assessments on the HVA plan must include specific safety risks and potential hazard vulnerabilities such as resident elopement throughout and around the memory care building including deactivation of power doors due to loss of power or from a fire alarm activation, potential of resident room windows being comprised, nearby highways, risks of harm from gas fireplace access, and the risks of the misuse of portable fire extinguishers or architectural accessories. - The HVA plan lacked mitigations and/or safety measures provided to safety risks assessment on and around the property including relevant hazards itemized on the Kaiser Permanente document to protect residents from harm. On January 19, 2022, at approximately 5:30 p.m., survey staff explained that all other potential safety risks on and around the property must be assessed and mitigated in the HVA plan to protect dementia care residents from harm. The administrator (A)-C and the licensed assisted living director (LALD)-D acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
02110 SS=C	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee	02110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30689	A. BUILDING: _____ B. WING _____	01/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HOMESTEAD AT COON RAPIDS	11372 ROBINSON DRIVE NW COON RAPIDS, MN 55433

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02110	Continued From page 42 must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living facility with dementia care provided the required policies and procedures to three of three residents (R1,	02110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30689	A. BUILDING: _____ B. WING _____	01/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HOMESTEAD AT COON RAPIDS	11372 ROBINSON DRIVE NW COON RAPIDS, MN 55433

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02110	Continued From page 43 R2 and R3) and the residents' legal and designated representatives at the time of move-in. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 admitted to licensee on November 7, 2017. R1's diagnoses included dementia (a group of symptoms that affects memory, thinking and interferes with daily life). R1's record lacked documentation of receipt of required policies and procedures to be provided to the residents and the residents' legal and designated representatives at the time of move-in. R2 admitted to licensee on December 7, 2015. R2's diagnoses included chronic obstructive pulmonary disease (COPD), diabetes mellitus type 2, and chronic kidney disease stage 3. R2's record lacked documentation of receipt of required policies and procedures to be provided to the residents and the residents' legal and designated representatives at the time of move-in. R3 admitted to licensee on December 16, 2021. R3's diagnoses included hypertension and diabetes mellitus type 2.	02110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30689	A. BUILDING: _____ B. WING _____	01/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HOMESTEAD AT COON RAPIDS	11372 ROBINSON DRIVE NW COON RAPIDS, MN 55433

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02110	Continued From page 44 R3's record lacked documentation of receipt of required policies and procedures to be provided to the residents and the residents' legal and designated representatives at the time of move-in. On January 13, 2022, at approximately 12:00 p.m., registered nurse (RN)-A, administrator (A)-C, licensed assisted living director (LALD)-D, and RN-E acknowledged the required policies to be provided to residents and the residents' legal and designated representatives at the time of move-in had not been created or provided to the residents. The licensee lacked a policy to provide required policies to residents and maintain documentation of receipt of policies in the resident record. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02110		

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

Type: Full
Date: *01/11/22*
Time: 15:29:31
Report: 8058221016

Food and Beverage Establishment Inspection Report

Location:
The Homestead At Coon Rapids
11372 Robinson Drive Nw
Coon Rapids, MN55433
Anoka County, 02

Establishment Info:
ID #: 0038799
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7632335100
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.

5-200B Plumbing: cross connections

5-203.14I ** Priority 1 **

MN Rule 4626.1085A Remove the control valve located on the discharge side of the atmospheric vacuum breaker backflow prevention device.

REMOVE HOSE FROM HOP SINK WHEN NOT IN USE

Corrected on Site

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.

RESIDENT FOOD STORED IN THE NEIGHBORHOOD KITCHEN IS NOT DATEMARKED

Corrected on Site

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.12A

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

ACCUMULATION OF FOOD DEBRIS SHOWN ON WALLS AND IN FLOORS BELOW EQUIPMENT

Comply By: 01/21/22

Surface and Equipment Sanitizers

Hot Water: = --- at 170 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Type: Full
Date: *01/11/22*
Time: 15:29:31
Report: 8058221016
The Homestead At Coon Rapids

Food and Beverage Establishment Inspection Report

Food and Equipment Temperatures

Process/Item: PBJ SANDWHICH
Temperature: 41 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

Process/Item: MILK
Temperature: 37 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

Process/Item: STEAK
Temperature: 157 Degrees Fahrenheit - Location: HOT HOLDING
Violation Issued: No

Process/Item: MILK
Temperature: 41 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

Process/Item: TUNA
Temperature: 41 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

Process/Item: HAM
Temperature: 156 Degrees Fahrenheit - Location: HOT HOLDING
Violation Issued: No

Process/Item: PIE
Temperature: 41 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

Process/Item: BEANS
Temperature: 40 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

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

COMMENTS:

KITCHEN CABINETS ARE LAMINATED WOOD WITH LAMINATED COUNTERS, IN BOTH INSTANCES THERE ARE LOCATIONS OF PEELING OR DAMAGED FINISHES.

WALLS AND CEILINGS ARE BOTH PAINTED DRYWALL SURFACES, WALLS HAVE A KNOCKDOWN TEXTURE AND CEILING IS A "POPCORN" FINISH.

DURING INSPECTION A SMALL DEEP FRYER WAS LOCATED IN THE CENTER OF THE KITCHEN AND NOT UNDER THE HOOD - THIS WAS CORRECTED ON SITE

RESIDENTIAL STYLE REFRIGERATOR USED IN NEIGHBORHOOD KITCHEN

HRD INSPECTION: BENARD NYANGENA

Type: Full
Date: *01/11/22*
Time: 15:29:31
Report: 8058221016
The Homestead At Coon Rapids

Food and Beverage Establishment Inspection Report

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 8058221016 of 01/11/22.

Certified Food Protection Manager: MICHELLE BARAJAS

Certification Number: 23280 Expires: 01/03/23

Inspection report reviewed with person in charge and emailed.

Signed: _____
Establishment Representative

Signed: _____
Inspector Number 8058
Sanitarian 3
MDH Metro Office
651 201 4500
health.foodlodging@state.mn.us