Electronically Delivered

August 14, 2024

Licensee
The Geneva Suites
11416 Wild Heron Point
Eden Prairie, MN 55347

RE: Project Number(s) SL34321015

Dear Licensee:

On July 18, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the May 2, 2024, survey were corrected. This follow-up survey verified that the facility is back in 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,

Renee L. Anderson

Renee Anderson, Supervisor
State Evaluation Team
Email: renee.anderson@state.mn.us
Telephone: 651-201-5871 Fax: 1-866-890-9290

JMD

Electronically Delivered

June 10, 2024

Licensee
The Geneva Suites
11416 Wild Heron Point
Eden Prairie, MN 55347

RE: Project Number(s) SL34321015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on May 2, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, 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. 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), MDH may impose fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. 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. 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 - 0470 - 144g.41 Subdivision 1 - Minimum Requirements - $3,000.00
St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00
St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - $3,000.00

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

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has

section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. to submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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,

Renee L Anderson

Renee Anderson, Supervisor
State Evaluation Team
Email: Renee.L.Anderson@state.mn.us
Telephone: 651-201-5871 Fax: 1-866-890-9290

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34321	A. BUILDING: _____ B. WING _____	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GENEVA SUITES	11416 WILD HERON POINT EDEN PRAIRIE, MN 55347

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL34321015-0 On April 29, 2024, through May 2, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were six resident(s); six receiving services under the provider's Assisted Living license. An immediate correction order for 0470 was identified on April 29, 2024. On April 30, 2024, at 4:52 p.m., the immediacy of the order was lifted, however the scope and level remain the same. An immediate correction order for 1290 was identified on May 1, 2024. On May 2, 2024, at 3:31 p.m., the immediacy of the order was lifted, however the scope and level remain the same.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	

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0 470	Continued From page 1	0 470		
0 470 SS=G	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (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 (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; (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: (i) awake; (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; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the facility had sufficient staffing to meet the scheduled and reasonably foreseeable unscheduled needs, as required by the resident's assessments and service plans on a 24-hour per day basis, for one of one resident (R1) who required a mechanical lift.	0 470		

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0 470	Continued From page 2 This resulted in an immediate correction order issued on April 29, 2024, at approximately 5:15 p.m. 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). The findings include: R1 had diagnoses including Guillain-Barre syndrome (a rare neurological disorder leading to weakness and paralysis). R1's service plan, dated April 29, 2024, indicated R1 received services including hands on assistance with transfers and mobility. The service plan indicated R1 required the assistance of two people to transfer with a mechanical lift. R1's assessment, dated March 14, 2024, indicated R1 required the assistance of two team members to evacuate in case of emergency. The licensee's schedule for the weeks of April 22, 2024, and April 29, 2024, indicated one unlicensed personnel (ULP) was scheduled for the night shift, 10:00 p.m. to 6:00 a.m. On April 29, 2024, at 11:30 a.m., during the entrance conference, clinical nurse supervisor (CNS)-A stated the licensee staffed two ULP for the day shift and evening shift, and one ULP for	0 470		

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0 470	Continued From page 3 the night shift, 10:00 p.m. to 6:00 a.m. The licensee further stated the night shift included a lead ULP that traveled to their different sister facilities (up to nine miles distance) as needed, to assist. On April 29, 2024, at 2:35 p.m., R1 stated it took two people to transfer him with the lift but on occasion one ULP completed the transfer because only one was available. On April 29, 2024, at 3:00 p.m., CNS-A stated they required two people at all times to transfer R1 to the bed and wheelchair. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a	0 480		

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0 480	Continued From page 4 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated May 1, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (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. (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. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to establish and maintain an effective infection control program to comply with accepted health care, medical, and nursing standards for	0 510		

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0 510	Continued From page 5 infection control. The licensee failed to ensure direct care staff performed adequate hand hygiene (HH) for two of two observed staff (unlicensed personnel (ULP)-C and ULP-D). 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 the potential to affect a large portion or all of the residents). The findings include: ULP-C was hired on April 4, 2024, and provided direct care services to the residents. ULP-D was hired April 21, 2020, under the comprehensive home care license and began providing assisted living services on August 1, 2021. On April 30, 2024, at 9:00 a.m., ULP-D was providing morning cares to R1 with assistance from ULP-C. ULP-D was wearing gloves at the beginning of the observation. ULP-D and ULP-C gave R1 a bed bath with gloves on. ULP-D replaced gloves twice while bathing the resident without performing HH. ULP-D applied gloves a third time, performed peri care, removed gloves, and replaced gloves without performing HH. ULP-D applied barrier cream to peri area, removed gloves, applied a new pair and dressed R1. ULP-D removed gloves and did not perform HH. ULP-D applied clean gloves and completed range of motion, removed gloves and did not complete HH.	0 510		

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0 510	Continued From page 6 On April 30, 2024, at 12:40 p.m., ULP-D stated he had infection control training. ULP-D stated he needed to wash his hands for 30 seconds or use sanitizer between each glove change. On August 30, 2024, at 1:00 p.m., clinical nursing supervisor (CNS)-A stated HH training was included in infection control training for staff, and staff were trained to perform HH for 20 seconds if using soap and water. CNS-A stated they did not officially document HH audits. The CDC guidance, CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings, revised November 29, 2022, indicated standard precautions were to be used to care for all patients (residents) in all settings, including HH, and noted, "Use an alcohol-based hand rub or wash with soap and water for the following clinical indications: a. Immediately before touching a patient. b. Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices. c. Before moving from work on a soiled body site to a clean body site on the same patient. d. After touching a patient or the patient's immediate environment. e. After contact with blood, body fluids or contaminated surfaces f. Immediately after glove removal." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		

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0 640	Continued From page 7	0 640		
0 640	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to support protection and safety by not posting information and phone numbers for reporting to the Minnesota Adult Abuse Reporting Center (MAARC) in the assisted living facility. This had the potential to affect all six (6) residents, staff, and visitors. 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). The findings include: On April 29, 2024, at 11:45 a.m., the surveyor was with assisted living director (ALD)-B and	0 640		

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0 640	Continued From page 8 observed the common area of the facility lacked a posting of the MAARC phone number. ALD-B stated there was no posting of the MAARC phone number elsewhere in the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640		
0 650 SS=F	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. This MN Requirement is not met as evidenced by:	0 650		

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0 650	Continued From page 9 Based on interview and record review, the licensee failed to ensure the employee record contained the required content to include a signed job description for two of two employees (unlicensed personnel (ULP)-C and licensed practical nurse (LPN)-L). 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 the potential to affect a large portion or all of the residents). The findings include: LPN-L was hired on February 7, 2024, and provided direct care services to the residents. ULP-C was hired on April 4, 2024, and provided direct care services to the residents. LPN-L and ULP-C's records lacked a job description. During an interview on May 1, 2024, at 11:05 a.m., assisted living director (ALD)-B stated they would provide the job descriptions for LPN-L and ULP-C. Job descriptions were not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		

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0 660	Continued From page 10	0 660		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included completing an annual facility TB risk assessment, symptom screening upon hire, and baseline testing for two of two employees (unlicensed personnel (ULP)-C, licensed practical nurse (LPN)-L). 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	0 660		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GENEVA SUITES	11416 WILD HERON POINT EDEN PRAIRIE, MN 55347

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0 660	Continued From page 11 failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's TB risk assessment, dated April 2022, indicated the facility was at a low risk for TB transmission. The licensee lacked a current TB Facility Risk Assessment, completed annually. LPN-L was hired on February 7, 2024, and provided direct care services to the residents. ULP-C was hired on April 4, 2024, and provided direct care services to the residents. LPN-L and ULP-C's employee records lacked documentation of a history and symptom screen and baseline TB testing completed upon hire. On May 1, 2024, at 1:30 p.m., assisted living director (ALD)-B stated they would provide updated documents. Documents were not provided. The licensee's Tuberculosis screening and prevention policy, dated August 1, 2021, indicated the licensee's "baseline testing is completed on hire" and "employees receive a baseline TB screening upon hire." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness	0 680		

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0 680	Continued From page 12 (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to have a written emergency preparedness (EP) plan with all the required content. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when	0 680		

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0 680	Continued From page 13 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: The licensee's EP plan, undated, lacked the following required content: -a plan for evacuation, addressed elements of sheltering in place, and detailed staff assignments in the event of a disaster or an emergency; -a process for cooperation and collaboration with local, tribal, regional, State and Federal emergency preparedness, to maintain integrated response; -documentation of participation in an annual full-scale exercise that was community based OR conducted an annual, individual, facility-based functional exercise OR if the facility experienced an actual emergency requiring activation of plan; -conducted an additional annual exercise that may have included: a second full-scale exercise that was community-based, or an individual, facility-based functional exercise, or mock disaster drill, or table-top exercise; and -analyzed the facility's response to and maintained documentation of all drills, tabletop exercises and emergency events, and revised plan as needed. On April 29, 2024, at 11:30 a.m., during the facility tour with assisted living director (ALD)-B, the facility was observed to lack posting of signage and/or information regarding the licensee's emergency disaster or preparedness plan. ALD-B stated the plan was not posted prominently. ALD-B also stated they did not complete drills on the EP plan.	0 680		

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0 680	Continued From page 14 The licensee's Emergency Preparedness policy, undated, indicated the licensee would perform an emergency drill at least every six months, and would post an emergency disaster plan prominently. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 720 SS=F	144G.43 Subd. 2 Access to records The facility must ensure that the appropriate records are readily available to employees and contractors authorized to access the records. Resident records must be maintained in a manner that allows for timely access, printing, or transmission of the records. The records must be made readily available to the commissioner upon request. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure that personnel and resident records were readily available for access to the commissioner upon request. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	0 720		

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0 720	Continued From page 15 During the entrance conference on April 29, 2024, at 10:50 a.m., assisted living director (ALD)-B stated that resident and employee records would be available to the surveyor using the licensee's electronic and paper records. At the end of the entrance conference, the surveyor drew the licensee's attention to the entrance email sent that morning and pointed out all the required documents after the facility tour. On April 30, 2024, at 10:03 a.m., the surveyor sent the licensee a reminder email of the required documents requested within one hour of the email: -discharge roster; -employee file for unlicensed personnel (ULP)-C and licensed practical nurse (LPN)-L (all training, supervision, education, tuberculosis (TB), and background study); -TB policy and procedure; -annual TB Facility Risk Assessment; -full emergency preparedness plan; and -emergency preparedness plan policy and procedure. In addition, the following were requested to be provided within two hours of the email: -R1's complete chart, including face sheet, service agreement, medication record, treatment record, contract, and medication orders. On April 30, 2024, at 12:00 p.m., the licensee sent, via email, R1's medication record, face sheet, and assessments. The licensee did not provide the other requested documents. On April 30, 2024, at 12:30 p.m., clinical nurse supervisor (CNS)-A stated ALD-B was collecting the documentation.	0 720		

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0 720	Continued From page 16 On April 30, 2024, at 12:32 p.m., the surveyor sent a follow-up email to CNS-A and ALD-B, listing the requested documents that were still needed. On April 30, 2024, at 4:05 p.m., the surveyors spoke with CNS-A and ALD-B. ALD-B stated she was still working on sending more records to the surveyors and that they would provide the records by May 1, 2024, at 8:00 a.m. The requested documents were not available on May 1, at 8:00 a.m. On May 1, 2024, at 11:00 a.m., ALD-B stated that they had many of the requested documents at another location and that this was why they were delayed in providing them. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 720		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique	0 810		

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0 810	Continued From page 17 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 the interview and record review, the licensee failed to develop the fire safety and evacuation plan (FSEP) with the required content and failed to provide the required drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 810		

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0 810	Continued From page 18 The findings include: An interview and record review were conducted on April 30, 2024, at 12:30 p.m. with assisted living director (ALD)-B on the fire safety and evacuation plan, fire safety and evacuation training for the facility, and fire safety and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN Record review of the available documentation indicated that the licensee did not maintain the fire safety and evacuation plan for the facility. Policies were requested on the fire safety and evacuation plan requirements, employee fire safety and evacuation training, resident training, and evacuation drills, but were not provided. During the facility tour on April 30, 11:30 a.m., it was observed that the standard RACE fire safety procedure was posted by the main entrance. During the interview, ALD-B verified that the standard RACE (Remove, Alarm, Confine, and Extinguish or Evacuate) acronym was the only available fire safety procedure at the time of the survey. ALD-B provided staff meeting minutes including fire still record from his commuter. The provided FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The fire safety and evacuation plan was a third-party consultant provided plan, and it was not updated to meet the facility-specific layout. The fire safety and evacuation plan included the RACE acronym as the fire safety procedure and instructed staff to	0 810		

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0 810	Continued From page 19 pull the nearest fire alarm in case of fire, but the facility did not have a fire alarm system. The FSEP did not include the facility-specific procedures for resident movement, evacuation or relocation during a fire or similar emergency. The facility Emergency Preparedness plan did include some provisions for the evacuation of residents but did not specify how to move or where to relocate residents during a fire, including the identification of unique or unusual resident needs for evacuation. Record review of the available documentation indicated that the licensee did not have fire protection procedures necessary for residents included in the fire safety and evacuation plan. During the interview on April 30, 2024, at 12:30 p.m., ALD-B stated the FSEP was from a third-party provider and verified the facility needed to update the fire safety and evacuation plan, including the facility-specific fire safety protocols. DRILLS Record review of the available documentation indicated that the licensee did not conduct evacuation drills twice per year per shift and every other month as required by statute. Provided documentation indicated that the drills were conducted as part of staff meeting on 3/3/23, 8/17/23, 10/12/23, 12/7/23 and 2/2/24 at 1:30 p.m., with no further drills being documented. During the interview on April 30, 2024, at 12:30 p.m., ALD-B stated the licensee was supposed to provide fire drills in every 9 weeks but provided quarterly only. He also confirmed that the	0 810		

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0 810	Continued From page 20 provided drills were conducted at 1:30 p.m. for morning shift only, and the facility failed to provide two drills for the afternoon and night shift. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal property of a resident. 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). The findings include: R1 and R4's's contracts, dated February 9, 2022,	0 970		

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0 970	Continued From page 21 and January 1, 2021, respectively, both included the following clauses that indicated the resident would waive the licensee's liability for health, safety, or personal property of a resident:. -the indemnification clause included resident will indemnify and hold harmless [Licensee] "against any and all claims, actions, damages, and liability and expense in connection with loss of life, personal injury or damage to property. -a liability clause which indicated "[Licensee] is not liable to Resident or Resident's guests for any injury, death or property damage occurring in the Room or on Provider's premises unless such injury, death or property damage occurs as the result of an equipment malfunction or hazardous conditions within the building not caused by Resident or Resident's guests. [Licensee] is also not liable for any injury, death or damage occurring as the result of Resident's receipt of health-related, supportive or other services from third party providers. On April 30, 2024, at 10:15 a.m., assisted living director (ALD)-B confirmed the above noted language was included in the assisted living contract which indicated the residents waived the facility's liability for health, safety, or personal property. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to	01290		

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01290	Continued From page 22 the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to ensure a Minnesota Department of Human Services (DHS) background study was submitted and a clearance received in affiliation with the assisted living license for ten of twelve employees (clinical nursing supervisor (CNS)-A, unlicensed personnel (ULP)-C, ULP-D, ULP-E, ULP-F, ULP-G, ULP-H, ULP-I, ULP-J, ULP-K). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). This resulted in an immediate correction order issued May 1, 2024, at 5:00 p.m. The findings include:	01290		

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01290	Continued From page 23 BACKGROUND STUDY NOT COMPLETED CNS-A was hired April 22, 2024, and provided supervision of staff, and direct care services for residents. CNS-A's record included documentation of a Minnesota Nursing License issued October 22, 2015. ULP-E was hired April 20, 2024, and provided direct care services for residents. CNS-A and ULP-E's employee records lacked documentation of a cleared background study prior to providing direct care services. On May 1, 2024, at 10:02 a.m., the Minnesota Department of Human Services (DHS) NETStudy 2.0 database was accessed, and indicated there was no background study conducted by the licensee for CNS-A or ULP-E BACKGROUND STUDY NOT AFFILIATED ULP-C was hired on April 2, 2024, and provided direct care assisted living services. ULP-F was hired on April 21, 2024, and provided direct care assisted living services. ULP-I was hired on June 5, 2021, and began providing assisted living services August 1, 2021. ULP-J was hired on September 26, 2023, and provided direct care assisted living services. ULP-D was hired on April 21, 2021, and began providing assisted living services August 1, 2021.	01290		

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01290	Continued From page 24 ULP-G was hired on September 30, 2020, and began providing assisted living services August 1, 2021. ULP-H was hired on August 16, 2017, and began providing assisted living services August 1, 2021. ULP-K was hired on December 19, 2022, and provided direct care assisted living services. On May 1, 2024, at 10:02 a.m., the Minnesota DHS NETStudy 2.0 database was accessed and indicated ULP-C, ULP-F, ULP-I, ULP-J had background studies affiliated with the licensee's sister-facility, health facility identification (HFID) 32138, but were not affiliated to the licensee, HFID 34321. Additionally, the database indicated ULP-D, ULP-G, ULP-H, ULP-K had background studies affiliated with the licensee's sister-facility, health facility identification (HFID) 32475, but were not affiliated to the licensee, HFID 34321. On May 1, 2024, at approximately 10:30 a.m., assisted living director (ALD)-D stated they were unaware the background study for CNS-A was needed because they were licensed by the board of nursing. ALD-D stated ULP-E had not completed the background study form correctly and he was not aware that it had not been resubmitted. ALD-D stated he was unaware that all staff had to be affiliated with the HFID where they were providing care. The licensee's Criminal background check policy, dated December 16, 2020, indicated the licensee would complete pre-employment background checks/studies as required for all employees. No further information was provided.	01290		

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01290	Continued From page 25 TIME PERIOD FOR CORRECTION: IMMEDIATE	01290		
01460 SS=D	144G.63 Subdivision 1 Orientation of staff and supervisors All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure staff providing services completed orientation to assisted living facility licensing requirements and regulations, before providing services, for one of three employees, license practical nurse (LPN)-L. 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: LPN-L was hired February 7, 2024, and provided direct care services to the residents.	01460		

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01460	Continued From page 26 LPN-L lacked a personnel record and documentation of orientation, completed before providing services, including: - Overview of Assisted Living statutes; - Review of provider's policies and procedures; - Handling emergencies and using emergency services; - Home care/Assisted Living bill of rights; - Handling of resident/clients' complaints, reporting of complaints, where to report; - Consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; - Review of types of Assisted Living services the employee will provide and provider's scope of license; and - Principles of person-centered planning/service delivery and how they apply to direct support services provided by the staff person. On April 30, 2024, at 10:05 p.m., assisted living director (ALD)-B stated he did not have documentation that orientation was provided to staff because nurses did not need orientation. On May 1, 2024, at 1:30 p.m., ALD-B provided orientation documentation for LPN-L dated April 30, 2024 (during the survey). ALD-B stated that he could not locate the original documentation and he recreated it. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01460		

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01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this	01500		

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01500	Continued From page 28 subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure employees received at least eight (8) hours of annual training for each 12 months of employment for one of two employees (unlicensed personnel (ULP)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-D was hired April 21, 2020, under the comprehensive home care license and began providing assisted living services on August 1,	01500		

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01500	Continued From page 29 2021. On May 1, 2024, at 10:15 a.m., the surveyor observed ULP-D administer medications to R1. ULP-D's employee record lacked documentation of 8 hours of annual training completed within the last year, including the following required topics: -review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; -review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; -review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. On May 1, 2024, at 11:30 a.m., ULP-D stated they were unsure if the required training was provided. On May 1, 2024, at 12:05 p.m., assisted living director (ALD)-B stated the documentation should be in the employee record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	01500		

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01500	Continued From page 30 (21) days	01500		
01530 SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure required dementia care training was completed for two of two employees (unlicensed personnel (ULP)-D and licensed practical nurse (LPN)-L).	01530		

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01530	Continued From page 31 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 the potential to affect a large portion or all of the residents). The findings include: ULP-D started employment on April 21, 2020, under the comprehensive home care license and began providing assisted living services on August 1, 2021. LPN-L was hired February 7, 2024, and provided direct care services to the residents. ULP-D and LPN-L's employee record's lacked evidence of at least eight hours of initial dementia training within 160 working hours of the employment start date to include: (1) an explanation of Alzheimer's disease and other dementias; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; (4) communication skills; and (5) person-centered planning and service delivery. Additionally, ULP-D's employee record lacked documentation of at least two hours of annual dementia training. On May 1, 2024, at 1:45 p.m., assisted living director (ALD)-A stated the employee record was missing the required dementia care training and	01530		

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01530	Continued From page 32 that he would provide the documents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01650 SS=D	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (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.	01650		

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01650	Continued From page 33 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident service plan included the required content for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1's service plan, dated October 6, 2021, indicated R1 received services, including assistance with medication management, activities of daily living (ADLs), toileting, and mobility. R1's care plan dated May 1, 2024, indicated "Resident is on supplemental O2 at 2L [oxygen at 2 liters per minute]. Please assist resident as requested for placement of nasal cannula and turn on concentrator. Please turn off concentrator when not in use. Check for safe storage of oxygen tanks and cleanliness of equipment. Check that storage tank is at least 2 feet from any wall. No storage tanks in closets or bathrooms. Check that all tubing and connections are secure and free of condensation." R1's service plan lacked information related to oxygen management.	01650		

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01650	Continued From page 34 On April 29, 2024, at 2:15 p.m., clinical nurse supervisor (CNS)-A stated they entered the residents' services into the electronic medical record (EMR) to develop the service plan. CNS-A stated they were planning to transition to another EMR platform and would need to ensure the correct elements were present in that form. CNS-A stated that service plans were not updated; only services in the EMR were updated. CNS stated that oxygen should be included on the service plan going forward. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
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	01790		

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01790	Continued From page 35 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: (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.	01790		

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01790	Continued From page 36 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) developed training and competencies for unlicensed personnel (ULP) who provided medications to residents for unplanned time away from home when the licensed nurse was not available for two of two employees (ULP-D and ULP-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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-C was hired on April 4, 2024, and provided direct care services to the residents. ULP-D was hired April 21, 2020, under the comprehensive home care license and began providing assisted living services on August 1, 2021. On May 1, 2024, at 10:15 a.m., ULP-D assisted R1 with medication administration. On May 1, 2024, at 10:20 a.m., ULP-D stated they did not recall training on preparing medications for residents for unplanned times away. ULP-C and ULP-D's records lacked documentation of training and competency by the	01790		

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01790	Continued From page 37 RN for providing medications to residents for unplanned time away when the RN was not available. On May 1, 2024, at 11:45 a.m., assisted living director (ALD)-B stated the records lacked documentation of training and competency by a RN for medication set-up by the ULP during a resident's unplanned time away. ALD-B stated he would provide the training and the policy. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01790		
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to dispose of expired medications and ensure medications were labeled correctly for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when	01890		

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01890	Continued From page 38 problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1's service plan, dated October 6, 2021, indicated R1 received services including assistance with activities of daily living (ADLs), housekeeping, and medication management. R2's service plan, dated March 13, 2024, indicated R2 received services including assistance with ADLs, housekeeping, and medication management. On April 29, 2024, at 11:20 a.m., during a review of the medication storage area, the following was observed: R1 had the following expired medications: poly-ethylene glycol powder (for constipation): expiration date March 30, 2024. trazadone 50 milligrams (mg) (for pain): expiration date March 21, 2024. tylenol 325 mg (for pain): expiration date January 19, 2024. R2 had the following expired medications: Senna 8.6 mg (for constipation): expiration date December 12, 2022. R3 had the following undated open medication: Vyzulta eye drops (reduce eye pressure). On April 29, 2024, at 11:40 a.m., unlicensed personnel (ULP)-D stated if he noticed a medication was expired, he would notify the nurse.	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34321	A. BUILDING: _____ B. WING _____	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GENEVA SUITES	11416 WILD HERON POINT EDEN PRAIRIE, MN 55347

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01890	Continued From page 39 On April 29, 2024, at 12:00 p.m., clinical nurse supervisor (CNS)-A stated expired medication should be removed by a nurse when the monthly medication shipment arrived. Manufacturer storage instructions for Vyzulta states that "Once a bottle is opened it may be stored at 2° to 25°C (36° to 77°F) for 8 weeks". The licensee's Medications - Prescription Drugs & Prohibition policy, dated August 1, 2021, indicated "the prescription drug must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug". No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01930 SS=F	144G.72 Subd. 2 Policies and procedures (a) An assisted living facility that provides treatment and therapy management services must develop, implement, and maintain up-to-date written treatment or therapy management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse or appropriate licensed health professional consistent with current practice standards and guidelines. (b) The written policies and procedures must address requesting and receiving orders or prescriptions for treatments or therapies, providing the treatment or therapy, documenting treatment or therapy activities, educating and	01930		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34321	A. BUILDING: _____ B. WING _____	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GENEVA SUITES	11416 WILD HERON POINT EDEN PRAIRIE, MN 55347

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01930	Continued From page 40 communicating with residents about treatments or therapies they are receiving, monitoring and evaluating the treatment or therapy, and communicating with the prescriber. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to develop, implement, and maintain up-to-date written treatment or therapy management policies and procedures that were developed under the supervision and direction of a clinical nurse supervisor (CNS)-A consistent with current practice standards and guidelines, 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 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 April 29, 2024, at approximately 11:00 a.m., during the entrance conference, assisted living director (ALD)-B and CNS-A confirmed the licensee provided treatment management services. The surveyor requested to review the licensee's policies and procedures upon entrance to the facility. R1's care plan dated May1, 2024, indicated resident received oxygen treatment. "Resident is on supplemental O2 at 2L [oxygen at 2 liters per minute]".	01930		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34321	A. BUILDING: _____ B. WING _____	05/02/2024

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01930	Continued From page 41 On May 1, 2024, at 11:15 a.m., the supervisor again asked CNS-A to provide the policy and procedure for treatment management. CNS-A stated he could not locate one in the computer system. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01930		
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 observation, interview, and record review, the licensee failed to obtain prescriber orders for all treatments and therapies, including the frequency, duration and other information needed to administer the treatment or therapy for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01970	Continued From page 42 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's service plan, dated October 6, 2021, indicated R1 received services, including assistance with activities of daily living, housekeeping, and medication management. R1's care plan stated "Resident is on supplemental O2 at 2L [oxygen at 2 liters per minute]. Please assist resident as requested for placement of nasal cannula and turn on concentrator. Please turn off concentrator when not in use. Check for safe storage of oxygen tanks and cleanliness of equipment. Check that storage tank is at least 2 feet from any wall. No storage tanks in closets or bathrooms. Check that all tubing and connections are secure and free of condensation." R1's record lacked an order for the oxygen treatment. On April 30, 2024, at 10:15 a.m., the surveyor asked clinical nurse supervisor (CNS)-A to provide an order for the oxygen treatment. CNS-A stated they did not have an order in the resident record. On May 1, 2024, CNS-A provided an order that indicated "Supplemental O2 2L/min to maintain O2 sats above 90%". The order was signed by the provider on May 1, 2024, at 9:36 a.m., during the survey. No further information was provided.	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34321	A. BUILDING: _____ B. WING _____	05/02/2024

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01970	Continued From page 43 TIME PERIOD OF CORRECTION: Seven (7) days	01970		

DEPARTMENT OF HEALTH

Type: Full
Date: *05/01/24*
Time: 12:13:12
Report: 1036241082

Food and Beverage Establishment Inspection Report

Location:
The Geneva Suites
11416 Wild Heron Point
Eden Prairie, MN55347
Hennepin County, 27

Establishment Info:
ID #: 0039040
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6122088888
ID #:

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

The following orders were issued during this inspection.

3-500B Microbial Control: hot and cold holding

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

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

ITEMS IN THE FRIDGE WERE OVER 41 DEGREES F. ALL TCS ITEMS IN FRIDGE WERE DISCARDED ON SITE. UNIT WAS TURNED DOWN, ADVISED TO MONITOR FRIDGE TEMPERATURE.

Comply By: 05/02/24

4-700 Sanitizing Equipment and Utensils

4-703.11B ***** Priority 1 *****

MN Rule 4626.0905B Sanitize food contact surfaces of equipment and utensils after cleaning by using mechanical hot water operations that achieve a utensil surface temperature of 160 degrees F (71 degrees C) and are set up and maintained in accordance with the specifications of NSF International and the manufacturer's data plate.

DISH MACHINE WAS NOT ABLE TO REACH THE REQUIRED UST OF 160 DF. ADVISED TO TURN UP WATER HEATER AND ENGAGE SANITIZER BUTTON OF DISH MACHINE. ALTERNATIVELY, A LARGE BUCKET WITH A SANITIZING SOLUTION MAY BE USED IF DISH MACHINE IS NOT ABLE TO REACH 160 DF.

Comply By: 05/22/24

4-300 Equipment Numbers and Capacities

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

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

NO DEVICE FOR MEASURING THE UST IN THE DISH MACHINE. MDH PROVIDED A COUPLE THERMOSTRIPS UNTIL SOME CAN BE OBTAINED.

Comply By: 05/22/24

2-100 Supervision

2-102.12DMN

MN Rule 4626.0033D Post the certified food protection manager certificate.

ENSURE THE ORIGINAL CFPM CERTIFICATE IS POSTED. EACH SITE MUST HAVE A DESIGNATED CFPM. INSTRUCTIONS FOR CFPM APPLICATION SENT ALONG WITH REPORT.

Comply By: 05/22/24

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

3-302.12

MN Rule 4626.0240 Properly label all working containers holding food or food ingredients that are removed from orginal packages with the common name of the food. Label the food in English and any other languages used by employees who handle food.

OBSERVED AN UNLABELED BAG IN THE CABINET. PER STAFF, ITEM WAS BROWN SUGAR. ISSUE CORRECTED ON SITE.

Comply By: 05/01/24

4-100 Equipment Construction Materials

4-101.17

MN Rule 4626.0490 Discontinue using wood and wood wicker as a food contact surface.

OBSERVED SOME WOOD SPOONS IN CABINET DRAWER. COMPLY WITH ABOVE RULE.

Comply By: 05/22/24

4-200 Equipment Design and Construction

4-201.11GMN

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

OBSERVED LEFTOVERS FOODS PREPARED THE PREVIOUS DAY AT COMMISSARY KITCHEN BEING COLD HELD IN THE FRIDGE AND REHEATED. DISCONTINUE SAVING AND SERVING LEFTOVERS.

Comply By: 05/02/24

4-300 Equipment Numbers and Capacities

4-303.11A

MN Rule 4626.0721A Provide cleaning agents to clean equipment and utensils during all hours of operation.

ESTABLISHMENT WAS ALL OUT OF LYSOL CLEANER. COMPLY WITH ABOVE RULE.

Comply By: 05/22/24

4-500 Equipment Maintenance and Operation

4-501.11AB

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

OBSERVED DAMAGE ON THE INTERIOR DOOR OF THE MICROWAVE. REPAIR OR REPLACE AND MAINTAIN.

Comply By: 05/22/24

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.12A

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

OBSERVED SOME FOOD DEBRIS/STAINS IN SEVERAL OF THE CABINETS AND DRAWERS. COMPLY WITH ABOVE RULE.

Comply By: 05/22/24

Surface and Equipment Sanitizers

UTENSIL SURFACE TEMP: < at 150 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: Yes

Food and Equipment Temperatures

Process/Item: Cold Hold/MILK
Temperature: 50 Degrees Fahrenheit - Location: KITCHEN FRIDGE
Violation Issued: Yes

Process/Item: Cold Hold/COTTAGE CHEESE
Temperature: 50 Degrees Fahrenheit - Location: KITCHEN FRIDGE
Violation Issued: Yes

Process/Item: Ambient Temp
Temperature: 57 Degrees Fahrenheit - Location: KITCHEN FRIDGE
Violation Issued: Yes

Process/Item: Ambient Temp
Temperature: 4 Degrees Fahrenheit - Location: KITCHEN FREEZER
Violation Issued: No

Type: Full
Date: *05/01/24*
Time: 12:13:12
Report: 1036241082
The Geneva Suites

Food and Beverage Establishment Inspection Report

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	2	1	7

THIS INSPECTION WAS CONDUCTED IN CONJUNCTION WITH MDH HEALTH REGULATORY DIVISION (HRD) SURVEY. SURVEYOR FROM HRD WAS ANGEL WOEHLER. INSPECTION CONDUCTED IN PRESENCE OF LESLIE KEMP, THE CFPM, AND LUIS BRIONES, DIRECTOR OF OPERATIONS. ALL VIOLATIONS WERE DISCUSSED WITH LESLIE, LUIS, AND SURVEYOR DURING INSPECTION.

THIS FACILITY DOES NOT HAVE COMMERCIAL GRADE ANSI EQUIPMENT. ALL FOOD MUST BE SERVED THE SAME DAY IT IS PREPARED, AND LEFTOVERS CAN NEVER BE SAVED.

DISCUSSED ALL ORDERS ON SITE IN ADDITION TO THE FOLLOWING WITH THE PERSON IN CHARGE:
- EMPLOYEE ILLNESS LOG AND EXCLUSION POLICY.
- HAND WASHING POLICY AND REVIEW.
- GLOVE USAGE.
- THERMOMETER USE AND CALIBRATION.
- DATE MARKING.
- PEST CONTROL.
- FULLY COOKING FOOD FOR HIGH RISK POPULATIONS.
- ANSI 184 STANDARD FOR RESIDENTIAL DISH WASHER.

FOR CORRECT BY DATES REFER TO COMPLETE REPORT ISSUED BY HRD.

*INSPECTOR WILL BE RETURNING FOR A FOLLOW-UP INSPECTION.

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

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the inspection report number 1036241082 of 05/01/24.

Certified Food Protection Manager: LESLIE KEMP

Certification Number: FM112097 Expires: 07/20/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
LUIS BRIONES
DIRECTOR OF OPERATIONS

Signed: _____
Jeff Johanson