



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

December 18, 2024

Licensee
United Homes Services
14570 Joppa Avenue South
Savage, MN 55378

RE: Project Number(s) SL36378015

Dear Licensee:

On November 13, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine the correction of orders from the June 12, 2024, survey and follow-up survey completed September 4, 2024. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'Jodi Johnson'.

Jodi Johnson, Supervisor
State Evaluation Team
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

JMD



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

October 8, 2024

Licensee
United Homes Services
14570 Joppa Avenue South
Savage, MN 55378

RE: Project Number(s) SL36378015

Dear Licensee:

On September 4, 2024, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on June 12, 2024. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the June 12, 2024 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on June 12, 2024, found not corrected at the time of the September 4, 2024, follow-up survey and/or subject to penalty assessment are as follows:

0430-Uniform Checklist Disclosure Of Services-144g.40 Subd. 2
0580-Quality Management-144g.42 Subd. 2 - \$500.00
0650-Employee Records-144g.42 Subd. 8
0660-Tuberculosis Prevention And Control-144g.42 Subd. 9
0680-Disaster Planning And Emergency Preparedness-144g.42 Subd. 10- \$500.00
0730-Contents Of Resident Record-144g.43 Subd. 3
1060-Emergency Relocation-144g.52 Subd. 9- \$500.00
1370-Training And Evaluation Of Unlicensed Personnn-144g.61 Subd. 2 (a)
1380-Training And Evaluation Of Unlicensed Personnn-144g.61 Subd. 2 (b)
1440-Supervision Of Staff Providing Delegated Nurs-144g.62 Subd. 4
1530-Training In Dementia Care Required-144g.64
1620-Initial Reviews, Assessments, And Monitoring-144g.70 Subd. 2 (c-E)
1760-Documentation Of Administration Of Medication-144g.71 Subd. 8

The details of the violations noted at the time of this follow-up survey completed on September 4, 2024 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Also, at the time of this follow-up survey completed on September 4, 2024, we identified the following violation(s):

0340-Correction Orders-144g.30 Subd. 5

The details of the violation(s) noted at the time of this follow-up survey are delineated on the attached State Form. Only the ID Prefix Tag in the left hand column without brackets will identify these state correction orders. It is not necessary to develop a plan of correction.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$1,500.00**. 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 outlined on the state form; however, plans of correction are not required to be submitted for approval.

IMPOSITION OF FINES:

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.

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 been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. to submit a hearing request, please visit:

<https://forms.web.health.state.mn.us/form/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.

We urge you to review these orders carefully. If you have questions, please contact Jodi Johnson at 507-344-2730.

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

Sincerely,

A handwritten signature in black ink, appearing to read "Jodi Johnson", with a long horizontal flourish extending to the right.

Jodi Johnson, Supervisor
State Evaluation Team
Email: Jodi.Johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36378	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 09/04/2024
NAME OF PROVIDER OR SUPPLIER UNITED HOMES SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 14570 JOPPA AVENUE SOUTH SAVAGE, MN 55378		
(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 In accordance with Minnesota Statutes, section 144G.08 to 144G.95 these correction orders have been issued pursuant to a survey. Determination of whether a violation has been 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: SL36378015-1 On September 3, 2024, through September 4, 2024, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on June 12, 2024. At the time of the survey, there were four residents; four receiving services under the Assisted Living license. As a result of the follow-up survey, the following orders were reissued.	{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 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.		
0 340 SS=F	144G.30 Subd. 5 Correction orders a) A correction order may be issued whenever the	0 340			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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0 340	Continued From page 1 commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, an agent of the facility, or an employee of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail or email copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have sufficient documentation with actions taken to comply with the correction orders for a revisit survey completed on September 4, 2024. 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	0 340			

Minnesota Department of Health

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0 340	Continued From page 2 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: During the revisit survey on September 4, 2024, a review of the licensee's policies and procedures, resident records, and employee records, lacked evidence to indicate the licensee had attempted to correct all the orders issued for the survey concluded on June 12, 2024. Reissued orders include: 0430, 0580, 0650, 0660, 0680, 1060, 1370, 1380, 1440, 1530, 1620, and 1760. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 340			
{0 430} SS=C	144G.40 Subd. 2 Uniform checklist disclosure of services (a) All assisted living facilities must provide to prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract.	{0 430}			

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{0 430}	Continued From page 3 (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a). This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to revise and provide an up-to-date Uniform Disclosure of Assisted Living Services & Amenities (UDALSA). 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: During the initial survey entrance conference on June 10, 2024, at 12:33 p.m. program director (PD)-B stated the licensee did not offer services related to ventilators, tube feeding, mechanical lifts, and complex wound care. The licensee's UDALSA dated December 15, 2022, included availability of the following services: - (IV) Intravenous management - PICC lines (Peripherally Inserted Central Catheter) - Medication delivery via enteral (feeding) tube - Pain pump management - Wound care: complex - Ventilators - Suctioning	{0 430}			

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{0 430}	Continued From page 4 - Arrange for On-Site Dialysis - Peritoneal Dialysis (on-site) - Integrative Health Services: acupuncture - Integrative Health Services: aromatherapy - Integrative Health Services: healing touch - Integrative Health Services: massage - Indwelling urinary catheter replacement by nurse - Straight (intermittent) catheter assistance - Transfers utilizing sit-to-stand lifts - Transfers utilizing bariatric equipment - Mechanical lift: assist of 1 transfer - Mechanical lift: assist of 2 transfer - Chair Glide System - Mechanical Stair Lift System - Emergency call system; specify type in comments (call button) - digital wander alert device on resident - Wander alert system at facility exits - Staff monitoring at facility exits - Bed alarms or movement sensing technology - Door sensors - Dietitian or Nutritionist Services - Activities Director: Full and part time During the initial survey on June 12, 2024, at 1:15 p.m. PD-B reviewed the licensee's UDALSA and stated the above services were not available. During the revisit survey on September 3, 2024, at 12:13 p.m. PD-B stated they had not attempted to correct the above discrepancies on the UDALSA.	{0 430}			
{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	{0 580}			

Minnesota Department of Health

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{0 580}	Continued From page 5 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. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to engage in and maintain documentation of quality management activity appropriate to the size and relevant to the type of services provided by the assisted living. This had the potential to affect all residents receiving assisted living services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the initial survey entrance conference on June 10, 2024, at 12:33 p.m. program director (PD)-B, stated having a quality management meeting about a year and a half ago, although not since then. The Quality Meeting minutes were reviewed and	{0 580}			

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{0 580}	Continued From page 6 had not been completed since September 7, 2022. During the revisit survey on September 3, 2024, at 12:13 p.m. PD-B stated they had not attempted to schedule or complete any quality management meetings or activities. The licensee's 2.31 Quality Management Project policy dated August 1, 2022, indicated the licensee will have at least one documented quality management project in place at all times and retain record of such projects for at least two years.	{0 580}			
{0 650} SS=E	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	{0 650}			

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{0 650}	Continued From page 7 (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records included an annual performance review for three of three employees (house manager (HM)-C, unlicensed personnel (ULP)-H, ULP-I). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: HM-C started employment on July 1, 2020. On June 11, 2024, at 8:25 a.m. HM-C was observed administering medications to R1. HM-C's last documented performance review was dated January 26, 2021. HM-C's record lacked a current annual performance review that identified areas of improvement needed and training needs. On June 12, 2024, at 1:15 p.m. program director (PD)-B stated HM-C's employee record did not include evidence of a current annual performance review.	{0 650}			

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{0 650}	Continued From page 8 During the revisit survey on September 3, 2024, at 12:13 p.m. PD-B stated they had not attempted to conduct an annual performance review for HM-C since the last survey. ULP-H ULP-H started employment on October 10, 2020, and began providing direct care assisted living services for the licensee on August 1, 2021. ULP-H's's last documented performance review was dated January 27, 2021. ULP-H's record lacked a current annual performance review that identified areas of improvement needed and training needs. ULP-I ULP-I started employment on May 17, 2021, and began providing direct care assisted living services for the licensee on August 1, 2021. ULP-I's record lacked evidence an annual performance review had been completed since hire. On September 4, 2024, at 9:40 a.m. PD-B stated annual performance reviews for ULP-H and ULP-I had not been completed as required.	{0 650}			
{0 660} SS=E	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	{0 660}			

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{0 660}	Continued From page 9 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) including documentation of completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test for three of three employees (unlicensed personnel (ULP)-E, ULP-F, ULP-G). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: The licensee's TB risk assessment dated July 4, 2023, indicated the licensee was a low risk. ULP-E was hired on November 1, 2023, to	{0 660}			

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{0 660}	Continued From page 10 provide direct care services to residents of the facility. ULP-E's employee's record contained a first-step TST administered May 12, 2023, (173 days prior to hire) and read on May 15, 2023. ULP-E's employee record lacked evidence other TB screening had been completed. On June 12, 2024, at 1:15 p.m. program director (PD)-B stated ULP-E's record lacked evidence TB testing had been completed upon hire as required. During the revisit survey on September 3, 2024, at 12:13 p.m. PD-B stated they had not attempted to complete TB testing for ULP-E since the last survey. ULP-F ULP-F was hired on January 9, 2024, to provide direct care services to residents of the facility. ULP-F's employee's record contained a first-step TST administered December 20, 2023, and read on December 22, 2023. ULP-F's employee record lacked evidence a second step TST had been completed as required. ULP-G ULP-G was hired on September 18, 2023, to provide direct care services to residents of the facility. ULP-G's employee's record contained a first-step TST administered July 5, 2023, and read on July 7, 2023. ULP-G's employee record lacked evidence a second step TST had been completed as required.	{0 660}			

Minnesota Department of Health

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{0 660}	Continued From page 11 During the revisit survey on September 4, 2024, at 9:42 a.m. PD-B stated ULP-F and ULP-G had not completed a second step TST as required. The Minnesota Department of Health, Regulations for Tuberculosis Control in Health Care Settings dated July 2013, indicated: Baseline TB screening is required for all HCWs (health care workers) (Table 3.1). Baseline TB screening consists of three components: 1. Assessing for current symptoms of active TB disease, 2. Assessing TB history, and 3. Testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step TST or single IGRA (Interferon Gamma Release Assay - a blood test used to see whether a person has been infected with the bacteria causing TB). An employee may begin working with patients after a negative TB symptom screen and a negative IGRA or TST (first step) dated within 0-days before hire. The second TST may be performed after the HCW starts working with patients. The licensee's 8.16 Tuberculosis Screening policy dated August 1, 2021, indicated: Screening will be conducted as follows: 1. New staff shall be screened for active signs of TB using the Baseline TB Screening Tool for HCWs 2. New staff shall have an IGRA blood test or a two-step Mantoux conducted with results documented on the Baseline TB Screening Tool for HCWs	{0 660}			

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{0 680}	Continued From page 12	{0 680}			
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies 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 plan with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff, and visitors at the assisted living facility license. This practice resulted in a level two violation (a violation that did not harm a resident's health or	{0 680}			

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{0 680}	Continued From page 13 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 the residents). The findings include: The licensee's Emergency Preparedness binder last reviewed October 3, 2023, lacked the following required content: - procedure for tracking staff and residents; - subsistence needs for staff and residents during emergency situations; - policies and procedures for medical documents; - policies and procedures for volunteers; - a communication plan that included: - primary and alternative means for communicating with facility staff, or federal, state, regional and local - policies and procedures to address role of facility under a waiver declared by the Secretary in accordance with section 1135 of the Act - EP testing/annual testing requirements. On June 12, 2024, at 1:15 p.m. program director (PD)-B stated the licensee lacked evidence of the above required content. During the revisit survey on September 3, 2024, at 12:13 p.m. PD-B stated they had not attempted to revise the Emergency Preparedness Plan or provide any emergency training to staff since the last survey. The licensee's Emergency Preparedness policy dated July 31, 2021, indicated the licensee will have an identified plan in place to assure the	{0 680}			

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{0 680}	Continued From page 14 safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services.	{0 680}			
{0 730} SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care	{0 730}			

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{0 730}	Continued From page 15 professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record included the required documentation related to hospitalization for one of one resident (R3). 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: During the revisit survey on September 3, 2024, at 12:13 p.m. clinical nurse supervisor (CNS)-D stated she had been documenting significant events in the resident records R3's start of care was June 7 2021, with diagnoses including type II diabetes.	{0 730}			

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{0 730}	Continued From page 16 R3's Service Plan-Waiver dated June 13, 2024, indicated R3 received assistance with medication set-up and administration, dressing, grooming, incontinence care, bathing reminders, blood glucose monitoring, housekeeping, laundry, and shopping/transportation assistance. R3's After Visit Summary dated August 11, 2024, indicated R3 had been admitted to the hospital on August 5, 2024, due to altered mentation, concerns for seizure-like episode which required intubation and management of care in the intensive care unit. R3 was discharged and returned to the licensee on August 11, 2024. R3's progress notes were requested for July 29, 2024, through September 3, 2024. There were no progress notes indicating what led up to R3's hospitalization. The first progress note provided was dated July 6, 2024, (one day after hospitalization) indicating the registered nurse at the dialysis center where R3 frequented, was informed of R3's admission to the hospital. No other details were indicated. On September 4, 2024, at 9:45 a.m. program director (PD)-B stated R3 had not felt well prior to hospitalization on August 5, 2024, experienced increased weakness and requested hospitalization. PD-B reviewed R3's record and stated it did not reflect evidence as to why R3 had been hospitalized. The licensee's 2.38 Resident Record - Information and Content policy dated August 1, 2022, indicated: Resident Records must include: 9. Documentation of significant changes in the resident's status and actions taken in response to	{0 730}			

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{0 730}	Continued From page 17	{0 730}			
{0 780} SS=F	the needs of the resident, including reporting to the appropriate supervisor or health care professional. 144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: No further action required	{0 780}			
{0 790} SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment	{0 790}			

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{0 790}	Continued From page 18 (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: No further action required	{0 790}			
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year	{0 810}			

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{0 810}	Continued From page 19 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: No further action required	{0 810}			
{01060} SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and	{01060}			

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{01060}	Continued From page 20 Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation and failed to notify the Office of Ombudsman for Long-Term Care of the emergency relocation for the licensee's one hospitalized resident (R3). 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	{01060}			

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{01060}	Continued From page 21 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: R3's start of care was June 7, 2021, with diagnoses including type II diabetes. R3's Service Plan-Waiver dated June 13, 2024, indicated R3 received assistance with medication set-up and administration, dressing, grooming, incontinence care, bathing reminders, blood glucose monitoring, housekeeping, laundry, and shopping/transportation assistance. R3's After Visit Summary dated August 11, 2024, indicated R3 had been admitted to the hospital on August 5, 2024, due to altered mentation, concerns for seizure-like episode which required intubation and management of care in the intensive care unit. R3 was discharged and returned to the licensee on August 11, 2024. R3's record lacked a written notice that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the Office of Ombudsman for Long-Term Care; - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section	{01060}			

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{01060}	Continued From page 22 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. In addition, the licensee failed to notify the Office of Ombudsman for Long-term Care when R3 did not return to the facility within four days. During the revisit survey on September 3, 2024, at 12:13 p.m. program director (PD)-B stated a written notice related to R3's emergency relocation had not been completed, and further lacked notification to the Office of Ombudsman for Long-Term Care that the resident had been relocated and had not returned to the facility within four days. PD-B further stated the licensee did not attempt to implement this requirement since the last survey.	{01060}			
{01370} SS=E	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting;	{01370}			

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{01370}	Continued From page 23 (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency was completed for three of three unlicensed personnel ((ULP)-E, ULP-F, ULP-G) to include all required content. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).	{01370}			

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{01370}	Continued From page 24 The findings include: ULP-E ULP-E was hired on November 1, 2023, to provide direct care services to residents of the facility. ULP-E's employee record lacked documentation of training for the following topics: - standby assistance techniques and how to perform them. On June 12, 2024, at 1:15 p.m. program director (PD)-B stated being unable to find evidence of the above training/competency for ULP-E. During the revisit survey on September 3, 2024, at 12:13 p.m. PD-B stated they had not attempted to complete the above training/competency since the last survey for ULP-E. ULP-F ULP-F was hired on January 9, 2024, to provide direct care services to residents of the facility. ULP-F's employee record lacked documentation of training for the following topics: - standby assistance techniques and how to perform them. ULP-G ULP-G was hired on September 18, 2023, to provide direct care services to residents of the facility. ULP-G's employee record lacked documentation of training for the following topics: - standby assistance techniques and how to perform them.	{01370}			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36378	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 09/04/2024
NAME OF PROVIDER OR SUPPLIER UNITED HOMES SERVICES		STREET ADDRESS, CITY, STATE, ZIP CODE 14570 JOPPA AVENUE SOUTH SAVAGE, MN 55378			
(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
{01370}	Continued From page 25 On September 4, 2024, at 9:44 a.m. PD-B stated the above training/competency had not been completed by ULP-F and ULP-G. The licensee's 5.02 Competency Training Evaluations policy dated August 1, 2022, indicated: 5. Training and competency evaluations for all ULP will include: g) Standby assistance techniques and how to perform them	{01370}			
{01380} SS=E	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency was completed for three of three unlicensed	{01380}			

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{01380}	Continued From page 26 personnel ((ULP)-E, ULP-F, ULP-G) to include all required content. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-E was hired on November 1, 2023, to provide direct care services to residents of the facility. ULP-E's employee record lacked documentation of training for the following topics: - safe transfer techniques and ambulation - range of motion and positioning On June 12, 2024, at 1:15 p.m. program director (PD)-B stated being unable to find evidence of the above trainings/competencies for ULP-E. During the revisit survey on September 3, 2024, at 12:13 p.m. PD-B stated they had not attempted to complete the above training/competency since the last survey for ULP-E. ULP-F ULP-F was hired on January 9, 2024, to provide direct care services to residents of the facility. ULP-F's employee record lacked documentation of training for the following topics:	{01380}			

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{01380}	Continued From page 27 - safe transfer techniques and ambulation - range of motion and positioning ULP-G ULP-G was hired on September 18, 2023, to provide direct care services to residents of the facility. ULP-G's employee record lacked documentation of training for the following topics: - safe transfer techniques and ambulation - range of motion and positioning On September 4, 2024, at 9:44 a.m. PD-B stated the above training/competency had not been completed for ULP-F and ULP-G. The licensee's 5.02 Competency Training Evaluations policy dated August 1, 2022, indicated competency evaluation for unlicensed personnel providing assisted living services must include: 6. e. Safe transfer techniques and ambulation f. Range of motion and positioning	{01380}			
{01440} SS=E	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a 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	{01440}			

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{01440}	Continued From page 28 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 interview and record review, the licensee failed to ensure direct supervision of staff performing delegated tasks was provided within 30 calendar days after the date on which the individual began working for the licensee for two of three employees (unlicensed personnel ((ULP)-E, ULP-G). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-E ULP-E was hired on November 1, 2023, to provide direct care services to residents of the facility.	{01440}			

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{01440}	Continued From page 29 ULP-E's employee record included a 30 Day Competency Evaluation form dated December 1, 2023, and signed by ULP-E and clinical nurse supervisor (CNS)-D on the same date. The form included a list of required trainings; however, it did not include evidence a delegated task had been observed by CNS-D. On June 12, 2024, at 1:15 p.m. program director (PD)-B reviewed ULP-E's 30-day competency evaluation and stated it did not include the required content. During the revisit survey on September 3, 2024, at 12:13 p.m. PD-B stated CNS-D had not attempted to complete/correct the required 30-day competency of a delegated task for ULP-E. ULP-G ULP-G was hired on September 18, 2023, to provide direct care services to residents of the facility. ULP-G's employee record included a 30 Day Competency Evaluation form dated October 17, 2023, and signed by ULP-E and CNS-D on the same date. The form included a list of required trainings; however, it did not include evidence a delegated task had been observed by CNS-D. On September 4, 2024, at 9:48 a.m. PD-B reviewed ULP-G's 30-day competency evaluation and stated it did not include the required content The licensee's Supervision of Unlicensed Personnel Performing Delegated Home Care Tasks, undated, indicated: 2. c. The direct supervision of staff performing	{01440}			

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{01440}	Continued From page 30	{01440}			
{01530} SS=E	delegated tasks must be provided within 30 days after the individual begins working for the home care provider and thereafter as needed based on performance. 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 three of three	{01530}			

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{01530}	Continued From page 31 employees ((house manager (HM)-C, unlicensed personnel (ULP)-H, ULP-I) completed at least two hours of dementia training annually as required. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: HM-C HM-C was hired on July 1, 2020, to provide direct care services to residents of the facility. HM-C's record lacked at least two hours of training on topics related to dementia for each 12 months of employment as required. On June 12, 2024, at 1:15 p.m. program director (PD)-B stated being unable to find evidence of the above required training for HM-C. During the revisit survey on September 3, 2024, at 12:13 p.m. PD-B stated they had not attempted HM-C's completion of the required annual dementia training. ULP-H ULP-H started employment on October 10, 2020, and began providing direct care assisted living services for the licensee on August 1, 2021. ULP-H's record lacked at least two hours of	{01530}			

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{01530}	Continued From page 32 training on topics related to dementia for each 12 months of employment as required. ULP-I ULP-I started employment on May 17, 2021, and began providing direct care assisted living services for the licensee on August 1, 2021. ULP-H's record lacked at least two hours of training on topics related to dementia for each 12 months of employment as required. On September 4, 2024, at 9:49 a.m. PD-B stated annual dementia training for ULP-H and ULP-I had not been completed as required. The licensee's 5.03 Dementia Training policy dated August 1, 2022, indicated all staff are required to complete dementia training at the time of hire and annually thereafter.	{01530}			
{01620} SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in	{01620}			

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{01620}	Continued From page 33 the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) failed to conduct a change of condition assessment following hospitalization for one of one resident (R3). 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: R3's start of care was June 7 2021, with diagnoses including type II diabetes. R3's Service Plan-Waiver dated June 13, 2024, indicated R3 received assistance with medication set-up and administration, dressing, grooming, incontinence care, bathing reminders, blood glucose monitoring, housekeeping, laundry, and shopping/transportation assistance.	{01620}			

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{01620}	Continued From page 34 R3's After Visit Summary dated August 11, 2024, indicated R3 had been admitted to the hospital on August 5, 2024, due to altered mentation, concerns for seizure-like episode which required intubation and management of care in the intensive care unit. R3 was discharged and returned to the licensee on August 11, 2024. R3's record did not include evidence a change of condition assessment had been completed upon return to the licensee. On September 4, 2024, at 9:51 a.m. program director (PD)-B reviewed R3's record and stated a change of condition assessment had not been completed by the registered nurse as required upon return from hospitalization. The licensee's 6.01 Assessments, Reviews & Monitoring policy dated August 1, 2022, indicated: 3. Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the need of the resident and cannot exceed 90 calendar days from the last date of the assessment. 6. The facility will conduct a nursing assessment during a holiday, and the weekend for a resident who is ready to be discharged from the hospital and return to the facility.	{01620}			
{01760} SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation	{01760}			

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{01760}	Continued From page 35 must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were set-up for administration by the registered nurse as ordered for 1 of 3 residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the revisit survey on September 3, 2024, at 12:13 p.m. clinical nurse supervisor (CNS)-D stated having a system for setting up resident's medications for administration. CNS-D stated she reviewed the current physician orders and updated the current medication administration record (MAR) as needed with any changes. CNS-D further stated she counted the medications set-up for each time of day to ensure all ordered medications had been set-up.	{01760}			

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{01760}	Continued From page 36 R1's diagnoses included closed fracture of right tibia and fibula with routine healing, depression, anxiety, and type II diabetes. R1's Service Plan (Waiver) dated September 3, 2024, indicated R1 received medication set-up and medication administration. R1's current discharge orders from the transitional care unit (TCU), dated May 24, 2024, included: - calcium carbonate-vitamin D 600-10 mg-mcg (milligram-microgram) tablet. Take one tablet by mouth two times a day - citalopram 40 mg tablet. Take one tablet by mouth daily. On September 3, 2024, at 1:35 p.m. CNS-D obtained R1's pill box which had medications previously set-up for September 4, 2024, through September 7, 2024, for the AM and PM medications passes. The surveyor observed CNS-D don gloves then poured R1's AM medications for September 4, 2024, into her hand. When reconciling the medications against R1's MAR and physician orders, it was revealed that R1's calcium carbonate-vitamin D and citalopram had not been set-up for the AM medication administration. CNS-D then reconciled R1's PM medications for September 4, 2024; these were accurate. CNS-D repeated the procedure for R1's medications set-up for September 5 - September 7, 2024. The AM dose of calcium carbonate-vitamin D, and citalopram were missing for each day of the AM set-up. CNS-D stated she set the medications up on a paper towel and counted them prior to putting them into the pill box and wasn't sure what happened.	{01760}			

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{01760}	Continued From page 37 The licensee's 7.09 Medication Management - Dosage Box Setup policy dated August 1, 2022, indicated: A licensed nurse will set up resident dosage boxes timely and accurately.	{01760}			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

July 8, 2024

Licensee
United Homes Services
14570 Joppa Avenue South
Savage, MN 55378

RE: Project Number(s) SL36378015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 12, 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 . . ."

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility.**

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>

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,



Jodi Johnson, Supervisor

State Evaluation Team

Email: Jodi.Johnson@state.mn.us

Telephone: 507-344-2730 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36378	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/12/2024
NAME OF PROVIDER OR SUPPLIER UNITED HOMES SERVICES		STREET ADDRESS, CITY, STATE, ZIP CODE 14570 JOPPA AVENUE SOUTH SAVAGE, MN 55378			
(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: SL36378015 On June 10, 2024, through June 12, 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 four residents; three receiving services under the provider's Assisted Living license.	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 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.		
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a	0 250			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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0 250	Continued From page 1 provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter;	0 250			

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0 250	Continued From page 2 (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required with records reviewed. 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: During the entrance conference on June 10,	0 250			

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0 250	Continued From page 3 2024, at 12:33 p.m., program director (PD)-B stated the licensee's employees in charge of the facility were familiar with the assisted living regulations and the licensee provided medication and treatment management services. The licensee's Application for Assisted Living License, section titled Official Verification of Owner or Authorized Agent, (page four and five of the application), identified, I certify I have read and understand the following: [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17. - I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G. - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659. - Reporting of Maltreatment of Vulnerable Adults. - Electronic Monitoring in Certain Facilities. - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will use information provided in this application, which	0 250			

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0 250	Continued From page 4 may include an in-person or telephone conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license. - I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. - I have examined this application and all	0 250			

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0 250	Continued From page 5 attachments and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page six was electronically signed by the licensee on December 25, 2023. The licensee had an assisted living license issued on March 1, 2024, with an expiration date of February 28, 2025. The licensee failed to ensure the following policies and procedures were developed and/or implemented: - orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; - conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; - conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; - medication and treatment management;	0 250			

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0 250	Continued From page 6 - delegation of tasks by registered nurses or licensed health professionals; and - supervision of unlicensed personnel performing delegated tasks. As a result of this survey, the following orders were issued 0650, 0660, 1370, 1380, 1440, 1530, 1620, 1760, 1820, 1940, and 2320 indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250			
0 430 SS=C	144G.40 Subd. 2 Uniform checklist disclosure of services (a) All assisted living facilities must provide to prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform	0 430			

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0 430	Continued From page 7 checklist disclosure form for use as provided under paragraph (a). This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to revise and provide an up-to-date Uniform Disclosure of Assisted Living Services & Amenities (UDALSA). 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: During the entrance conference on June 10, 2024, at 12:33 p.m. program director (PD)-B stated the licensee did not offer services related to ventilators, tube feeding, mechanical lifts, and complex wound care. The licensee's UDALSA dated December 15, 2022, included availability of the following services: - (IV) Intravenous management - PICC lines (Peripherally Inserted Central Catheter) - Medication delivery via enteral (feeding) tube - Pain pump management - Wound care: complex - Ventilators - Suctioning - Arrange for On-Site Dialysis - Peritoneal Dialysis (on-site)	0 430			

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0 430	Continued From page 8 - Integrative Health Services: acupuncture - Integrative Health Services: aromatherapy - Integrative Health Services: healing touch - Integrative Health Services: massage - Indwelling urinary catheter replacement by nurse - Straight (intermittent) catheter assistance - Transfers utilizing sit-to-stand lifts - Transfers utilizing bariatric equipment - Mechanical lift: assist of 1 transfer - Mechanical lift: assist of 2 transfer - Chair Glide System - Mechanical Stair Lift System - Emergency call system; specify type in comments (call button) - digital wander alert device on resident - Wander alert system at facility exits - Staff monitoring at facility exits - Bed alarms or movement sensing technology - Door sensors - Dietitian or Nutritionist Services - Activities Director: Full and part time On June 12, 2024, at 1:15 p.m. PD-B reviewed the licensee's UDALSA and stated the above services were not available. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 430			
0 470 SS=F	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;	0 470			

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0 470	Continued From page 9 (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 observation, interview, and record review the licensee failed to ensure the staff posting included all the required elements, potentially affecting all the licensee's current 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).	0 470			

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0 470	Continued From page 10 The findings included: On June 10, 2024, at approximately 12:15 p.m. the surveyor reviewed the postings on the wall near the dining area. The posted staff schedule was dated May 20, 2024, thru June 2, 2024. The surveyor notified program director (PD)-B, who stated it was not current. The licensee's Staffing Plan revised June 2024, indicated: 4. The daily work schedule must be posted, after redacting direct-care staff members' resident assignments, at the beginning of each work shift in a central location in each building of a facility or campus, accessible to staff, residents, volunteers, and the public. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 470			
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 11 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to engage in and maintain documentation of quality management activity appropriate to the size and relevant to the type of services provided by the assisted living. This had the potential to affect all residents receiving assisted living services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on June 10, 2024, at 12:33 p.m. program director (PD)-B, stated having a quality management meeting about a year and a half ago, although not since then. The Quality Meeting minutes were reviewed and had not been completed since September 7, 2022. The licensee's 2.31 Quality Management Project policy dated August 1, 2022, indicated the licensee will have at least one documented quality management project in place at all times and retain record of such projects for at least two years. No further information was provided.	0 580			

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0 580	Continued From page 12	0 580			
0 650 SS=D	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: Based on observation, interview, and record review, the licensee failed to ensure employee records included an annual performance review for one of one employee (house manager (HM)-C).	0 650			

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0 650	Continued From page 13 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: HM-C started employment on July 1, 2020. On June 11, 2024, at 8:25 a.m. HM-C was observed administering medications to R1. HM-C's last documented performance review was dated January 26, 2-21. HM-C's record lacked a current annual performance review that identified areas of improvement needed and training needs. On June 12, 2024, at 1:15 p.m. program director (PD)-B stated HM-C's employee record did not include evidence of a current annual performance review. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650			
0 660 SS=D	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	0 660			

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0 660	Continued From page 14 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) including documentation of completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test for one of two employees (unlicensed personnel (ULP)-E). 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: The licensee's TB risk assessment dated July 4,	0 660			

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0 660	Continued From page 15 2023, indicated the licensee was a low risk. ULP-E was hired on November 1, 2023, to provide direct care services to residents of the facility. ULP-E's employee's record contained a first-step TST administered May 12, 2023, (173 days prior to hire) and read on May 15, 2023. ULP-E's employee record lacked evidence other TB screening had been completed. On June 12, 2024, at 1:15 p.m. program director (PD)-B stated ULP-E's record lacked evidence TB testing had been completed upon hire as required. The Minnesota Department of Health, Regulations for Tuberculosis Control in Health Care Settings dated July 2013, indicated: Baseline TB screening is required for all HCWs (health care workers) (Table 3.1). Baseline TB screening consists of three components: 1. Assessing for current symptoms of active TB disease, 2. Assessing TB history, and 3. Testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step TST or single IGRA (Interferon Gamma Release Assay - a blood test used to see whether a person has been infected with the bacteria causing TB). An employee may begin working with patients after a negative TB symptom screen and a negative IGRA or TST (first step) dated within 0-days before hire. The second TST may be performed after the HCW starts working with patients.	0 660			

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0 660	Continued From page 16 The licensee's 8.16 Tuberculosis Screening policy dated August 1, 2021, indicated: Screening will be conducted as follows: 1. New staff shall be screened for active signs of TB using the Baseline TB Screening Tool for HCWs 2. New staff shall have an IGRA blood test or a two-step Mantoux conducted with results documented on the Baseline TB Screening Tool for HCWs 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 (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	0 680			

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0 680	Continued From page 17 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 plan with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff, and visitors at the assisted living facility license. 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 the residents). The findings include: The licensee's Emergency Preparedness binder last reviewed October 3, 2023, lacked the following required content: - procedure for tracking staff and residents; - subsistence needs for staff and residents during emergency situations; - policies and procedures for medical documents; - policies and procedures for volunteers; - a communication plan that included: - primary and alternative means for communicating with facility staff, or federal, state, regional and local - policies and procedures to address role of	0 680			

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0 680	Continued From page 18 facility under a waiver declared by the Secretary in accordance with section 1135 of the Act - EP testing/annual testing requirements. On June 12, 2024, at 1:15 p.m. program director (PD)-B stated the licensee lacked evidence of the above required content. The licensee's Emergency Preparedness policy dated July 31, 2021, indicated the licensee will have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any;	0 730			

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0 730	Continued From page 19 (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record included the required documentation related to hospitalization 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	0 730			

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0 730	Continued From page 20 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 start of care was November 1, 2020, with diagnoses including type II diabetes, asthma, depression, and anxiety. R1's unsigned, Service Plan-Waiver printed June 12, 2024, indicated R1 received assistance with medication set-up and administration, bathing, grooming, incontinence care, blood glucose monitoring, housekeeping, laundry, and shopping/transportation assistance. R1's Discharge Instructions and Recapitulation form from the transitional care unit (TCU) indicated R1 had been admitted on February 7, 2024, following hospitalization and discharged on May 30, 2024. R1's progress note dated May 30, 2024, indicated clinical nurse supervisor (CNS)-D had met with R1 upon return from the TCU. The last progress note prior to this was dated December 27, 2023; there were no progress notes related to R1's hospitalization and subsequent admission to the TCU. On June 11, 2024, at 1:35 p.m. CNS-D stated R1 had been in a motor vehicle accident and was hospitalized on February 2, 2024. Following hospitalization, R1 was transferred to the TCU on February 7, 2024, and returned to the assisted living on May 30, 2024. CNS-D reviewed R1's	0 730			

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0 730	Continued From page 21 progress notes and stated they did not include documentation of R1's hospitalization or admission to the TCU. The licensee's 2.38 Resident Record - Information and Content policy dated August 1, 2022, indicated: Resident Records must include: 9. Documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional. No further information was provided. TIME PERIOD FOR CORRECTIONS: Twenty-one (21) days	0 730			
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so	0 780			

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0 780	Continued From page 22 that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that are interconnected so that the actuation of one alarm causes all alarms in the dwelling unit to actuate. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: During the facility tour on June 11, 2024, at 1:00 p.m. with the program director (PD)-B, it was observed that the sleeping rooms equipped with smoke alarms were not interconnected upon testing, so actuation of one alarm would cause all alarms to operate. During the interview on June 11, 2024, at 1:30 p.m., PD-B stated the smoke alarms in the facility were not interconnected, and the actuation of one	0 780			

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0 780	Continued From page 23 alarm would not cause all alarms to operate. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780			
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to perform the required annual maintenance on fire extinguishers and failed to provide adequately rated portable fire extinguishers as required. This had the potential to affect all current 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	0 790			

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0 790	Continued From page 24 a large portion or all of the residents). The findings include: On June 11, 2024, at 1:00 p.m., survey staff toured the facility with program director (PD)-B. It was also observed the fire extinguisher did not have a service tag showing it had been inspected annually. It was observed that the fire extinguisher provided was 1-A:10-BC (size) rated and did not have at least one 2-A:10-B:C rated fire extinguisher as required. On June 11, 2024, at 1:30 p.m., PD-B verified required maintenance had not been completed and the facility did not have an appropriate size fire extinguisher. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790			
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or	0 810			

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0 810	Continued From page 25 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 interview and record review, the licensee failed to develop a fire safety and evacuation plan with the required elements and failed to conduct required evacuation drills as required. 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 26 The findings include: On June 11, 2024, at 1:30 p.m., program director (PD)-B provided documentation on the fire safety and evacuation plan (FSEP), fire safety and evacuation training for the facility, and fire safety and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The posted emergency evacuation plan did not show the location and number of resident rooms. The FSEP included the following discrepancies: The FSEP indicated residents should be evacuated to the safest exit or nearest set of smoke compartment doors away from fire and smoke. This facility was a residential home and did not contain any sort of smoke compartments or smoke compartment doors to contain fire and smoke. The FSEP indicated when the fire alarm is triggered, all fire doors on magnetic holders will automatically close to contain smoke and fire and residents are to remain behind these doors. The facility did not have any doors that are on magnetic door holders or doors that are rated for smoke and fire. The facility also did not have a fire alarm system that supports the use of magnetic door holders. The FSEP indicated the system was wired directly to the fire station. The facility did not have a fire alarm system that supported the direct connection to the fire station. The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or	0 810			

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0 810	Continued From page 27 similar emergency relative to the facility's building layout and environmental risks. The FSEP was provided by a third-party consultant, and it was not updated to meet the facility-specific layout. The FSEP included the RACE (Remove, Alarm, Confine and Extinguish or Evacuate) acronym as the fire safety procedure and instructed staff to pull the nearest fire alarm and close fire doors in case of fire, but the facility did not have a fire alarm system or fire doors. The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan failed to include ways to move, evacuate residents based on the facility's specific layout in the event of a fire or similar emergency. During the interview on June 11, 2024, at 2:00 p.m., PD-B stated the fire safety and evacuation plan 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. Record of the fire drill was requested, but one was not provided. During the interview on June 10, 2024, at 3:30 p.m., PD-B stated that the drills were conducted twice a year, but they were not documented. PD-B verified that there were no further	0 810			

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0 810	Continued From page 28 documented drills for the facility and verified this deficient condition. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative;	01060			

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01060	Continued From page 29 (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation and failed to notify the Office of Ombudsman for Long-Term Care of the emergency relocation 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) 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's start of care was November 1, 2020, with diagnoses including type II diabetes, asthma, depression, and anxiety. R1's unsigned Service Plan-Waiver printed June 12, 2024, indicated R1 received assistance with medication set-up and administration, bathing, grooming, incontinence care, blood glucose	01060			

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01060	Continued From page 30 monitoring, housekeeping, laundry, and shopping/transportation assistance. R1's Discharge Instructions and Recapitulation form from the transitional care unit (TCU) indicated R1 had been admitted on February 7, 2024, following hospitalization, and discharged on May 30, 2024. R1's record lacked a written notice that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the Office of Ombudsman for Long-Term Care; - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. On June 11, 2024, at 2:50 p.m. program director (PD)-B stated a written notice related to R1's emergency relocation had not been completed, and further lacked notification to the Office of Ombudsman for Long-Term Care that the resident had been relocated and had not returned to the facility within four days. PD-B stated being unaware of this requirement. No further information was provided. TIME PERIOD TO CORRECT: Twenty-one (21)	01060			

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01060	Continued From page 31 days	01060			
01370 SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family;	01370			

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01370	Continued From page 32 (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency was completed for one of two unlicensed personnel (ULP-E) to include all required content. 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: ULP-E was hired on November 1, 2023, to provide direct care services to residents of the facility. ULP-E's employee record lacked documentation of training for the following topics: - standby assistance techniques and how to perform them. On June 12, 2024, at 1:15 p.m. program director (PD)-B stated being unable to find evidence of the above training/competency for ULP-E. The licensee's 5.02 Competency Training Evaluations policy dated August 1, 2022, indicated:	01370			

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01370	Continued From page 33 5. Training and competency evaluations for all ULPs will include: g) Standby assistance techniques and how to perform them No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370			
01380 SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency was completed for one of two unlicensed personnel (ULP-E) to include all required content. This practice resulted in a level two violation (a	01380			

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01380	Continued From page 34 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: ULP-E was hired on November 1, 2023, to provide direct care services to residents of the facility. ULP-E's employee record lacked documentation of training for the following topics: - safe transfer techniques and ambulation - range of motion and positioning On June 12, 2024, at 1:15 p.m. program director (PD)-B stated being unable to find evidence of the above trainings/competencies for ULP-E. The licensee's 5.02 Competency Training Evaluations policy dated August 1, 2022, indicated competency evaluation for unlicensed personnel providing assisted living services must include: 6. e. Safe transfer techniques and ambulation f. Range of motion and positioning No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380			
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs	01440			

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01440	Continued From page 35 (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 interview and record review, the licensee failed to ensure direct supervision of staff performing delegated tasks was provided within 30 calendar days after the date on which the individual begins working for the licensee for one of one employee (unlicensed personnel (ULP)-E). 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	01440			

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01440	Continued From page 36 residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-E was hired on November 1, 2023, to provide direct care services to residents of the facility. ULP-E's employee record included a 30 Day Competency Evaluation form dated December 1, 2023, and signed by ULP-E and clinical nurse supervisor (CNS)-D on the same date. The form a list of required trainings though did not include evidence a delegated task had been observed by CNS-B. On June 12, 2024, at 1:15 p.m. program director (PD)-B reviewed ULP-E's 30-day competency evaluation and stated it did not include the required content. The licensee's Supervision of Unlicensed Personnel Performing Delegated Home Care Tasks, undated, indicated: 2. c. The direct supervision of staff performing delegated tasks must be provided within 30 days after the individual begins working for the home care provider and thereafter as needed based on performance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440			
01530 SS=D	144G.64 TRAINING IN DEMENTIA CARE REQUIRED	01530			

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01530	Continued From page 37 (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 one of one employee (house manager (HM)-C) completed at least two hours of dementia training annually as required. 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	01530			

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01530	Continued From page 38 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: HM-C was hired on July 1, 2020, to provide direct care services to residents of the facility. HM-C's record lacked at least two hours of training on topics related to dementia for each 12 months of employment as required. On June 12, 2024, at 1:15 p.m. program director (PD)-B stated being unable to find evidence of the above required training for HM-C. The licensee's 5.03 Dementia Training policy dated August 1, 2022, indicated all staff are required to complete dementia training at the time of hire and annually thereafter. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01530			
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living	01620			

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01620	Continued From page 39 services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive reassessment not to exceed 90 calendar days from the last assessment for one of one resident (R1), and failed to conduct a change of condition assessment following hospitalization 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:	01620			

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01620	Continued From page 40 R1's unsigned Service Plan-Waiver printed June 12, 2024, indicated R1 received assistance with medication set-up and administration, bathing, grooming, incontinence care, blood glucose monitoring, housekeeping, laundry, and shopping/transportation assistance. R1's last two assessments were requested. Assessments dated October 30, 2023, and July 11, 2023, were provided. 111 days had passed between the July and October 2023 assessments (21 days late). In addition, R1's next 90 day assessment was due by January 28, 2024, and was not completed. R1's Discharge Instructions and Recapitulation form from the transitional care unit (TCU) indicated R1 had been admitted on February 7, 2024, following hospitalization, and discharged on May 30, 2024. R1's record did not include evidence a change of condition assessment had been completed upon return to the licensee. On June 11, 2024, at 1:35 p.m. clinical nurse supervisor (CNS)-D stated R1 had been in a motor vehicle accident and was hospitalized on February 2, 2024. Following hospitalization R1 was transferred to the TCU (transitional care unit) on February 7, 2024, and returned to the assisted living on May 30, 2024. CNS-D stated she did not complete a full assessment upon R1's return and further stated prior assessments were late. The licensee's 6.01 Assessments, Reviews & Monitoring policy dated August 1, 2022, indicated: 3. Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the need of the	01620			

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01620	Continued From page 41 resident and cannot exceed 90 calendar days from the last date of the assessment. 6. The facility will conduct a nursing assessment during a holiday, and the weekend for a resident who is ready to be discharged from the hospital and return to the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620			
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced	01640			

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01640	Continued From page 42 by: Based on observation, interview, and record review, the licensee failed to ensure a written service plan was revised and signed to reflect the current services provided 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 diagnoses included closed fracture of right tibia and fibula with routine healing, depression, anxiety, and type II diabetes. R1's unsigned, Service Plan-Waiver printed June 12, 2024, indicated R1 received assistance with medication set-up and administration, bathing, grooming, incontinence care, blood glucose monitoring, housekeeping, laundry, and shopping/transportation assistance. On June 12, 2024, at 10:55 a.m. R1 was observed seated at the desk in the lower level of the residence; R1 had a controlled ankle movement (CAM) boot on her lower right leg. R1 stated she was in a motor vehicle accident on February 2, 2024, had surgery on her right leg, and then was in a transitional care unit (TCU) from February 6, 2024, until May 30, 2024. R1 stated upon return, R1 has needed extra help with showering, dressing, and ambulating up and	01640			

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01640	Continued From page 43 down the stairs. R1 further stated she'd been wearing the CAM boot since prior to return to the licensee. R1's current discharge orders from the TCU dated May 24, 2024, included: - Staff to help pt (patient) remove boot 1x/day (once daily) for skin check and per ortho (orthopedics) R1's service plan did not include daily boot removal and skin checks to R1's right lower leg. On June 12, 2024, at 1:15 p.m. program director (PD)-B and clinical nurse supervisor (CNS)-D reviewed R1's current discharge orders from the TCU and stated the order for removal of the CAM boot and daily skin check had not been added to R1's service plan and should have been revised. PD-B further stated being unaware resident service plans required the resident's signature when revised. The licensee's 6.08 Service Plan policy dated August 1, 2022, indicated: 3. Service plans shall be revised, if needed, based on resident reassessments and monitoring. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01640			
01760 SS=E	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the	01760			

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01760	Continued From page 44 resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered as ordered for 2 of 2 residents (R3, R1), and failed to transcribe all medication orders accurately for one of two residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R3 R3's diagnoses included type II diabetes. R3's undated Service Plan (Waiver) printed June 12, 2024, indicated R3 received medication set-up and medication administration.	01760			

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01760	Continued From page 45 R3's current hospital discharge orders dated April 26, 2024, included: - gabapentin 100 milligrams (mg). Take 100 mg by mouth three times daily. Take at 0800 (8:00 a.m.), 1200 (12:00 p.m.), and 2000 (8:00 p.m.). - lurasidone 60 mg. Take 60 mg by mouth once daily with lunch. On June 11, 2024, at 7:50 a.m. house manager (HM)-C was observed preparing to administer medications to R3. R3's oral medications had been previously set up in a medi-minder pill box by clinical nurse supervisor (CNS)-D. HM-C opened the Tuesday AM slot and poured the existing pills into a medication cup, which then contained 9 pills. HM-C was unable to identify what each pill was; although HM-C brought up R3's medication administration record (MAR) to see what pills had been set up. The MAR indicated there should be 10 pills, not 9 as identified. At 8:07 a.m., HM-C placed a call to CNS-D. HM-C stated CNS-D was on her way to the residence and would wait for her arrival to reconcile the medications before administering. R3 On June 11, 2024, at 9:35 a.m. CNS-D reviewed R3's medication pill bottles to reconcile with the physician orders, MAR, and what had been set-up for the resident. CNS-D indicated to the surveyor the set-up probably wouldn't be correct. The surveyor observed CNS-D reconcile R3's set-up medications with the following findings: - gabapentin 100 mg (milligrams) Take 100 mg by mouth three times daily. Take at 0800, 1200, and 2000. This medication was set up for administration; however, it was transcribed in the MAR to take twice daily at noon and 8:00 p.m. - lurasidone 60 mg. Take 60 mg by mouth once	01760			

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01760	Continued From page 46 daily with lunch. This medication was set up with R1's 8:00 a.m. medications. - sevelemer 800 mg tablet. Take two tablets by mouth three time a day with meals, was transcribed in the MAR, and also documented as set-up by CNS-D. There was no current order for this medication, and it was not set-up. CNS-D stated she would need to review all R1 and R3's set-up medications and MARs for accuracy with the resident's current physician orders as the set-up and transcription was inaccurate. R1 R1's diagnoses included closed fracture of right tibia and fibula with routine healing, depression, anxiety, and type II diabetes. R1's undated, Service Plan (Waiver) printed June 12, 2024, indicated R1 received medication set-up and medication administration. R1's current discharge orders from the transitional care unit (TCU), dated May 24, 2024, included: - acetaminophen 325 mg tablet. Take three tablets (975 mg) by mouth three times a day - anastrozole 1 mg tablet. Take one tablet (1 mg) by mouth daily - aripiprazole 5 mg tablet. Take one tablet (5 mg) by mouth daily. - calcium carbonate-vitamin D 600-10 mg-mcg (microgram) tablet. Take one tablet by mouth two times a day. - Preservision Areds. Take two capsules by mouth two times a day with meals. On June 11, 2024, at 8:09 a.m. HM-C was observed preparing to administer medications to R1. R1's oral medications had also been	01760			

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01760	Continued From page 47 previously set up in a medi-minder pill box by CNS-D. HM-C opened the Tuesday AM slot and poured the existing pills into a medication cup, which then contained 11 pills. HM-C was unable to identify what each pill was though brought up R1's MAR to see what pills had been set up. The MAR indicated there should be 15 total medications, not 11 as identified. HM-C stated he would also hold R1's medications for administration until CNS-D arrived. On June 11, 2024, at 8:25 a.m. CNS-D arrived at the residence. CNS-D obtained all R1 and R3's medication pill bottles to reconcile with the physician orders, MAR, and what had been set-up for each resident. The surveyor observed CNS-D first reconcile R1's set-up medications with the following findings: - acetaminophen 325 mg tablet. Take three tablets (975 mg) by mouth three times a day - was not set-up in the medi-minder, although was documented as set-up by CNS-D. - anastrozole 1 mg tablet. Take one tablet (1 mg) by mouth daily- was not set-up in the medi-minder, although was documented as set-up by CNS-D. - aripiprazole 5 mg tablet. Take one tablet (5 mg) by mouth daily - two pills were set up in the medi-minder, although was documented as set up by CNS-D. - calcium carbonate-vitamin D 600-10 mg-mcg (microgram) tablet. Take one tablet by mouth two times a day - was not set-up in the medi-minder, although was documented as set-up by CNS-D. - Preservision Areds. Take two capsules by mouth two times a day with meals - was not set-up in the medi-minder, although was documented as set-up by CNS-D. - hydroxyzine 10 mg by mouth every six hours prn (as needed) - was set-up in the medi-minder by	01760			

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01760	Continued From page 48 CNS-D. There was no current physician order for this medication and was also not included on the MAR or documented as set-up by CNS-D. At 8:53 a.m., CNS-D stated R1's discharge orders from the TCU dated May 24, 2024, were the most current orders. CNS-D further stated she thought she had reconciled all the orders but apparently hadn't. CNS-D then stated she wanted to review R1's noon medication set-up as she thought an aspirin 81 mg tablet had been set-up for R1. CNS-D reviewed R1's noon medications that had been previously set-up which included one aspirin 81 mg; CNS-D stated R1 did not have a current order for this medication. CNS-D proceeded to fill R1's missing 8:00 a.m. medications. CNS-D set up acetaminophen 500 mg, two tablets (1000 mg) not the prescribed acetaminophen 325 mg, three tablets (975 mg). CNS-D stated she had requested this order be changed by the physician but hadn't heard back yet. CNS-D then set-up anastrozole 1 mg. CNS-D then removed one of the Abilify 5 mg tablets and stated R1 used to have an order for two tablets and set the medication up that way as that was what they'd "been doing for months". CNS-D then set up calcium carbonate-vitamin D 600-10 mg-mcg and stated this was a "new order" for R1; however, it was on the May 24, 2024, discharge orders, and was documented as set-up. CNS-D looked for the Preservision Areds medication and stated this was also a new order (and was on the May 24, 2024, discharge orders) and they hadn't received it yet; however, it was documented as set-up. CNS-D then removed the hydroxyzine 10 mg tablet and stated R1 used to have an order for this and previously had requested it be set-up in the morning without having to ask for it. At 9:17 p.m., HM-C prompted R1 to come to the dining room for her medications. HM-C and CNS-D	01760			

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01760	Continued From page 49 administered R1's medications which included the acetaminophen 500 mg, 2 tablets (1000 mg), without authorization from the physician. The licensee's 7.09 Medication Management - Dosage Box Setup policy dated August 1, 2022, indicated: A licensed nurse will set up resident dosage boxes timely and accurately. 1. A licensed nurse will assure the medication orders are transcribed onto the Medication Administration Record (MAR). This profile includes: a. Dates of medication set up b. Medication name c. Quantity of dose d. Times to be administered e. Route of administration f. Name of the person completing the medication setup g. Visual description of medication h. Drug classification and special precautions 2. The licensed nurse transcribes the medications order onto the MAR. For medications included in the dosage box, the day and time of administration will be noted of the MAR. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01760			
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed	01820			

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01820	Continued From page 50 medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a current written or electronically recorded prescription was obtained for all medications the provider had managed for one of two residents (R1) observed during medication administration. 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 record lacked signed prescriber orders for two medications set up for administration by clinical nurse supervisor (CNS)-D. R1's diagnoses included type II diabetes and anxiety. R1's Service Plan printed June 12, 2024, included medication set-up and administration. On June 11, 2024, at 8:09 a.m. house manager (HM)-C was observed preparing R1's medications for administration from a medi-minder that had been previously set-up by CNS-D. HM-C opened the Tuesday AM (morning) medication slot and poured the oral	01820			

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01820	Continued From page 51 medications into a medication cup. The surveyor asked HM-C how he knew which medications had been set up for R1. HM-C referred the surveyor to R1's electronic medication administration record (MAR) which listed the following prescribed AM oral medications for R1: - acetaminophen 325 mg (milligrams), take three tabs by mouth three times a day - anastrozole 1 mg by mouth daily in the AM - aripiprazole 5 mg by mouth daily - calcium/D3 600-10 tab, one tab by mouth twice a day - citalopram 40 mg by mouth daily in the AM - metformin 500 mg, take two tabs by mouth twice a day with food - mybetriq 50 mg by mouth daily in the AM - oxybutynin 10 mg ER (extended release) by mouth daily in the AM - vitamin D3 1000 units by mouth daily in the AM - gabapentin 100 mg by mouth three times a day - Preservision Areds cap, take two capsules by mouth twice a day with meals - buspirone 10 mg by mouth twice a day The surveyor counted the number of pills HM-C poured into the medication cup; there were 11 pills. According to R1's MAR, there should have been 16 pills. HM-C stated he did not know which medications were missing and would hold the medication until CNS-D arrived to review. On June 11, 2024, at 8:25 a.m. CNS-D arrived at the facility. CNS-D retrieved R1's medication bottles and proceeded to reconcile the medications she had previously set up for that morning. CNS-D stated R1's most current orders were signed May 24, 2024. CNS-D identified one of the set-up medications as hydroxyzine 10 mg. The label on the bottle it had been set up from indicated: hydroxyzine 10 mg by mouth every 6 hours prn (as needed). R1's current physician	01820			

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01820	Continued From page 52 orders signed May 24, 2024, did not include an order for the hydroxyzine. CNS-D also opened up R1's 12:00 p.m. medication slot and observed the medications she had previously set up for administration, included was one aspirin 81 mg tablet. CNS-D reviewed R1's physician orders and stated there was no order for the aspirin. CNS-D further stated thought she had reconciled R1's meds upon return from the TCU but apparently hadn't. The licensee's 7.16 Medication & Treatment Orders - Implementing policy dated August 1, 2022, indicated: 1) Upon receipt of a medication and/or treatment order, whether new or change of an order from an authorized prescriber, a licensed nurse must take action to implement the order within 24 hours. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820			
01940 SS=D	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	01940			

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01940	Continued From page 53 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 (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 observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all 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:	01940			

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01940	Continued From page 54 During the entrance conference on June 10, 2023, at 12:33 p.m., clinical nurse supervisor (CNS)-D stated the licensee provided treatment management services to their residents. R1's diagnoses included closed fracture of right tibia and fibula with routine healing, depression, anxiety, and type II diabetes. R1's unsigned, Service Plan-Waiver printed June 12, 2024, indicated R1 received assistance with medication set-up and administration, bathing, grooming, incontinence care, blood glucose monitoring, housekeeping, laundry, and shopping/transportation assistance. On June 12, 2024, at 10:55 a.m. R1 was observed seated at the desk in the lower level of the residence; R1 had a controlled ankle movement (CAM) boot on her lower right leg. R1 stated she was in a motor vehicle accident on February 2, 2024, had surgery on her right leg and then was in a transitional care unit (TCU) from February 6, 2024, until May 30, 2024. R1 stated upon return, R1 has needed extra help with showering, dressing, and ambulating up and down the stairs. R1 further stated she'd been wearing the CAM boot since prior to return to the licensee. R1's current discharge orders from the transitional care unit (TCU) dated May 24, 2024, included: - Staff to help pt (patient) remove boot 1x/day (once daily) for skin check and per ortho (orthopedics) - Monitor blood glucose one time a day. Keep a record and bring to your primary care clinic visits. R1's service plan did not include daily boot	01940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36378	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/12/2024
NAME OF PROVIDER OR SUPPLIER UNITED HOMES SERVICES		STREET ADDRESS, CITY, STATE, ZIP CODE 14570 JOPPA AVENUE SOUTH SAVAGE, MN 55378			
(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
01940	Continued From page 55 removal and skin checks to R1's right lower leg. In addition, R1's record did not include evidence staff had been documenting R1's daily blood glucose value and providing results to the primary care physician. R1's records lacked a treatment management plan to include the following required content for CAM boot and blood glucose checks: - procedures for notifying a registered nurse when a problem arose with treatments or therapy services; and - 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. On June 12, 2024, program director (PD)-B and clinical nurse supervisor (CNS)-D reviewed R1's current discharge orders from the TCU and stated the order for removal of the CAM boot and daily skin check had not been added to R1's service plan and should have been revised. PD-B further stated he had just added the blood glucose checks to R1's service plan that day and staff had not yet started to document the service. The licensee's 7.05 Treatment & Therapy Management Plan policy dated August 1, 2022, indicated: 1. [Licensee] will develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: a. A statement of the type of services that will be provided. b. Documentation of specific resident instructions relating to the treatments or therapy	01940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36378	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/12/2024
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01940	Continued From page 56 administration. c. Identification of treatment or therapy tasks that will be delegated to unlicensed personnel. d. Procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services. e. Any resident-specific requirements relating to documentation of treatment and therapy received. f. Verification that all treatment and therapy was administered as prescribed. g. Monitoring of treatment or therapy to prevent possible complications or adverse reactions. 2. The treatment or therapy management record must be current and updated when there are any changes. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940			
02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure delegated	02320			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36378	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/12/2024
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02320	Continued From page 57 procedures were followed for one of two residents (R1) observed during medication administration. 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 diagnoses included type II diabetes and anxiety. R1's Service Plan printed June 12, 2024, included medication set-up and administration. On June 11, 2024, at 8:09 a.m. house manager (HM)-C was observed preparing R1's medications for administration from a medi-minder that had been previously set-up by CNS-D. After reviewing the previously set-up medications with the surveyor, HM-C held R1's AM medications until CNS-D could review for accuracy. R1's physician orders signed May 24, 2024, included an order for Breo Ellipta 200-25 mcg (micrograms). Inhale one dose daily. Rinse mouth/gargle after use. On June 11, 2024, at 8:25 a.m. CNS-B arrived at the facility and reconciled R1's AM medications with what had been previously set-up for administration. At 9:17 a.m., HM-C prompted R1 to come to the dining room table for her AM	02320			

Minnesota Department of Health

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02320	Continued From page 58 medications. HM-C and CNS-B were each present observing R1 take her oral medications, then Breo Ellipta inhaler. After self-administering the inhaler, R1 then took a drink of her water while HM-C and CNS-B observed. Neither HM-C or CNS-B prompted R1 to rinse and gargle after administration of the Breo Ellipta inhaler. On June 11, 2024, at 1:35 p.m. CNS-B stated R1 should have been prompted/educated on the need to rinse mouth with water/gargle, then spit out water following administration of the Ellipta inhaler. The manufacturer's Breo Ellipta Instructions for Use dated May 2023, indicated: Step 6. Rinse your mouth with water after you have used the inhaler and spit the water out. Do not swallow the water. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320			

Type: Full
Date: 06/10/24
Time: 13:00:00
Report: 1047241125

Food and Beverage Establishment Inspection Report

Page 1

Location:

United Homes Services
14570 Joppa Avenue South
Savage, MN55378
Scott County, 70

Establishment Info:

ID #: 0037535
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7632731168
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.

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

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

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: Refrigerator-milk
Violation Issued: No

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: Refrigerator drawer- turkey
Violation Issued: No

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

The inspection was completed with the operator and reviewed with MDH Nurse Evaluator W. Buckholz.

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

A two basin sink is located in the kitchen. One sink basin is designated for hand washing. A residential dish machine is located in the kitchen for dish washing & sanitizing.

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

Type: Full
Date: 06/10/24
Time: 13:00:00
Report: 1047241125
United Homes Services

Food and Beverage Establishment Inspection Report

Page 2

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 1047241125 of 06/10/24.

Certified Food Protection Manager Ali Mohamed

Certification Number: FM110824 Expires: 01/18/25

Inspection report reviewed with person in charge and emailed.

Signed: _____

Ali Mohamed
PIC

Signed: _____

Holly Sievers
Public Health Sanitarian 2
Metro Office
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