



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

October 8, 2025

Licensee

The James Inc.

10549 Beard Avenue South

Bloomington, MN 55431

RE: Project Number(s) SL28558016

Dear Licensee:

On August 27, 2025, 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 November 14, 2025. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the November 14, 2024 survey.

The Department of Health concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on November 14, 2024, found not corrected at the time of the August 27, 2025, follow-up survey and/or subject to penalty assessment are as follows:

1620 - Initial Reviews, Assessments, And Monitoring - 144g.70 Subd. 2 (c-E) - \$500.00

The details of the violations noted at the time of this follow-up survey completed on August 27, 2025 (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 August 27, 2025, we identified the following violation(s):

0340 - Correction Orders - 144g.30 Subd. 5 - \$500.00

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 \$1,000.00. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders outlined on the state form; however, plans of correction are not required to be submitted for approval.

IMPOSITION OF FINES

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

Level 1: no fines or enforcement;

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;

Level 3: a fine of \$1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

Level 4: a fine of \$3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

Level 5: a fine of \$5,000 per violation, 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 Jess Schoenecker at 651-201-3789.

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,



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

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 08/27/2025
NAME OF PROVIDER OR SUPPLIER THE JAMES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431			
(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 FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SL28558016-3 On August 27, 2025, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a follow-up survey completed on June 12, 2025. At the time of the survey, there were four residents; four receiving services under the Assisted Living Facility 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	0 340			

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 08/27/2025
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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	
0 340	Continued From page 1 (a) A correction order may be issued whenever the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, an agent of the facility, or staff 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: (1) 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; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide sufficient documentation with actions taken to comply with the correction orders from a survey completed November 14, 2024, a follow up survey completed on April 9, 2025, and a follow up survey completed on June 12, 2025. The lack of action to ensure compliance with regulations had the potential to affect all residents receiving services from the licensee.	0 340			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 08/27/2025
NAME OF PROVIDER OR SUPPLIER THE JAMES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431			
(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
0 340	Continued From page 2 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On March 13, 2025, the licensee received an enforcement letter, with the results of the survey completed on November 14, 2024. The enforcement letter included citation 1620 (Statue 144G.70 Subd 2. (c-e) Initial reviews, assessments, and monitoring), and indicated a period of correction of 21 days to be completed from March 13, 2025, to April 3, 2025. On August 11, 2025, the licensee received an enforcement letter, with the results of the follow up survey completed on June 12, 2025. The enforcement letter included a re-issued citation for 1620. The licensee's survey completed on November 14, 2024, identified non-compliance with citation 1620, which also identified continued non-compliance during the follow-up surveys completed on April 9, 2025, and June 12, 2025. The licensee's Correction Order Response - [licensee] signed April 12, 2025, under the section titled Tag #1620 - 144G.70 Subd. 2(c-e): Missing nursing assessments, indicated the cause was due to assessment schedule not	0 340			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 08/27/2025
NAME OF PROVIDER OR SUPPLIER THE JAMES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431			
(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
0 340	Continued From page 3 clearly tracked or enforced; the correction action was to complete 14-day and 90-day re-assessment for all residents using the state-mandated assessment tool; and a completion date of April 15, 2025 (which was after the period of correction allowed). The licensee failed to complete a re-assessment on all residents to include the uniform assessment tool as required by rule. On August 27, 2025, at 2:57 p.m., during an exit conference, licensed assisted living director/registered nurse (LALD/RN)-A acknowledged they had not updated their plan of correction for citation 1620 since April 12, 2025, and had not completed re-assessments utilizing the uniform assessment tool as indicated by the licensee. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 340			
{0 480} SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently	{0 480}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 08/27/2025
NAME OF PROVIDER OR SUPPLIER THE JAMES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431			
(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
{0 480}	Continued From page 4 enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door.	{0 480}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 08/27/2025
NAME OF PROVIDER OR SUPPLIER THE JAMES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431			
(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
{0 480}	Continued From page 5	{0 480}			
	This MN Requirement is not met as evidenced by:		Not reviewed during the survey.		
{01620} SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan 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. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part	{01620}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 08/27/2025
NAME OF PROVIDER OR SUPPLIER THE JAMES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431			
(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
{01620}	Continued From page 6 of the resident's reassessment. (e) 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 the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) 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) conducted ongoing resident monitoring and reassessment, utilizing a uniform assessment tool content per Minnesota Rules chapter 4659.0150 for four of four residents (R2, R3, R4, R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	{01620}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 08/27/2025
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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
{01620}	Continued From page 7 The findings include: On August 27, 2025, at 2:24 p.m., licensed assisted living director/registered nurse (LALD/RN)-A provided R2, R3, R4, and R5's Service Plan/ 90 day Monitoring/ Reassessment Form and stated the documents were the licensee's full nursing assessments. The combined documents lacked the following required assessment content per Minnesota Rules chapter 4659.0150: - the resident's personal lifestyle preferences; - activities of daily living; - instrumental activities of daily living; - physical health status; - emotional and mental health conditions; - cognition; - communication and sensory capabilities; - pain; - skin conditions; - nutritional and hydration status and preferences; - list of treatments, including type, frequency, and level of assistance needed; - nursing needs, including potential to receive nursing-delegated services; - risk indicators; - who has decision-making authority for the resident; and - the need for follow-up referrals for additional medical or cognitive care by health professionals. R2 R2 was admitted May 4, 2018, and had diagnoses including bipolar affective disorder (a mental health disorder causing extreme mood shifts), major neurocognitive disorder (a decline in mental function), and polysubstance abuse	{01620}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 08/27/2025
NAME OF PROVIDER OR SUPPLIER THE JAMES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431			
(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
{01620}	Continued From page 8 (the use of more than one drug). R2's Service Plan / 90 day Monitoring / Reassessment Form dated July 20, 2025, indicated R2 received services that included assistance with medication administration. R3 R3 was admitted November 25, 2022, and had diagnoses including schizophrenia (a serious mental health disorder that affects how people think, feel, and behave), and major depressive disorder. R3's Service Plan / 90 day Monitoring / Reassessment Form dated July 21, 2025, indicated R3 received services that included assistance with medication administration, behavior management, transportation, shopping, bathing, dressing, grooming, oral hygiene, laundry, and housekeeping. R4 R4 was admitted April 3, 2015, and had diagnoses including schizoaffective disorder (a chronic mental illness), cognitive impairment, and type two diabetes (insulin resistance). R4's Service Plan / 90 day Monitoring / Reassessment Form dated July 21, 2025, indicated R4 received services that included medication management, behavior management, transportation, shopping, laundry, and housekeeping. R5 R5 was admitted on February 19, 2016, and had diagnosis including schizophrenia.	{01620}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 08/27/2025
NAME OF PROVIDER OR SUPPLIER THE JAMES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431			
(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
{01620}	Continued From page 9 R5's Service Plan / 90 day Monitoring / Reassessment Form dated July 21, 2025, indicated R5 received services that included medication management, behavior management, transportation, shopping, laundry, and housekeeping. R2, R3, R4, and R5's records lacked a comprehensive assessment conducted by a RN which addressed the required uniform assessment tool content as identified in Minnesota Rules chapter 4659.0150. On August 27, 2025, at 2:57 p.m., licensed assisted living director/register nurse (LALD/RN)-A stated they would assess the residents upon admission, 14 days after they moved into the facility and then every 90 days after. LALD/RN-A stated for re-assessments, they would assess the resident ability to perform activities of daily living, if the resident required any reminders, medication needs such as ability to self-administer medications or if assistance was needed, mental health needs, and their ability to cook and feed themselves. LALD/RN-A stated they check to see what the residents' needs are and what the licensee needed to do for the resident. LALD/RN-A stated the licensee had used the uniform assessment tool for the initial assessments but did not use the uniform assessment tool on subsequent assessments. The licensee's 6.01 Assessment, Reviews & Monitoring policy dated June 1, 2024, indicated re-assessments would include all the elements of the uniform assessment tool as required, conducted in person, be in writing, dated, and signed by the registered nurse who conducted the assessment.	{01620}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 08/27/2025
NAME OF PROVIDER OR SUPPLIER THE JAMES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431			
(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
{01620}	Continued From page 10 The licensee's 6.03 Uniform Assessment Tool policy dated June 30, 2024, indicated all areas of the uniform assessment tool to be assessed. Minnesota Administrative Rule 4659.0140, subpart 2, B., (3) dated August 11, 2021, indicated the nursing assessment or reassessment must be conducted using a uniform assessment tool that complied with part 4659.0150. Minnesota Administrative Rule 4659.0150, subpart 2 dated August 11, 2021, indicated the required elements of the uniform assessment tool to comprehensively evaluate a resident's physical, mental, and cognitive needs. This citation had an original correction date period of 21 days to be completed from March 13, 2025, to April 3, 2025. No additional information was provided.	{01620}			
{03090} SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by:	{03090}	Not reviewed during the survey.		



Protecting, Maintaining and Improving the Health of All Minnesotans

AMENDED

Electronically Delivered

August 11, 2025

Licensee
The James Inc
10549 Beard Avenue South
Bloomington, MN 55431

RE: Project Number(s) SL28558016

Dear Licensee:

Please Note: This letter amends the previous letter dated August 8, 2025. Specifically corrected is the list of state correction orders issued pursuant to the last survey, completed on November 14, 2024, found not corrected at the time of the June 12, 2025, follow-up survey and/or subject to penalty assessment. No other changes have been made.

On June 12, 2025, 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 November 14, 2025. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the November 14, 2024 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on November 14, 2024, found not corrected at the time of the June 12, 2025, follow-up survey and/or subject to penalty assessment are as follows:

1620-Initial Reviews, Assessments, And Monitoring-144g.70 Subd. 2 (c-E) - \$500.00
3090-Notice To Visitors-144.6502, Subd. 8

The details of the violations noted at the time of this follow-up survey completed on June 12, 2025 (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.

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

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

Level 2: a fine of \$500 per violation, 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 Renee L. Anderson at 651-201-5871.

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,



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

HHH



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

August 8, 2025

Licensee

The James Inc

10549 Beard Avenue South

Bloomington, MN 55431

RE: Project Number(s) SL28558016

Dear Licensee:

On June 12, 2025, 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 November 14, 2025. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the November 14, 2024 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on November 14, 2024, found not corrected at the time of the June 12, 2025, follow-up survey and/or subject to penalty assessment are as follows:

3090-Notice To Visitors-144.6502, Subd. 8 - \$500.00

The details of the violations noted at the time of this follow-up survey completed on June 12, 2025 (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.

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

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

Level 2: a fine of \$500 per violation, 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 Renee L. Anderson at 651-201-5871.

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,



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

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 06/12/2025
NAME OF PROVIDER OR SUPPLIER THE JAMES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431			
(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 FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SL28558016-2 On June 11, 2025, through June 12, 2025, 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 April 9, 2025. At the time of the survey, there were four (4) 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.		
{0 480} SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	{0 480}			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 06/12/2025
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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	
{0 480}	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are	{0 480}			

Minnesota Department of Health
STATE FORM 6899 JN9S13 If continuation sheet 3 of 9

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 06/12/2025
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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
{01620}	Continued From page 3 (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) 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 the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) 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) conducted ongoing resident monitoring and reassessment, utilizing a uniform assessment tool content per Minnesota Rules chapter 4659.0150 for four of four residents (R2, R3, R4, and R5).	{01620}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 06/12/2025
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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
{01620}	Continued From page 4 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On June 11, 2025, at 4:52 p.m., licensed assisted living director/registered nurse (LALD/RN)-A provided R2, R3, R4, and R5's Service Plan/90 day Monitoring/reassessment forms and Individualized Abuse Prevention Plan assessment documents and stated documents were licensee's completed RN assessments. The combined documents lacked the following required assessment content per Minnesota Rules chapter 4659.0150: - the resident's personal lifestyle preferences; - activities of daily living; - instrumental activities of daily living; - physical health status; - emotional and mental health conditions; - cognition; - communication and sensory capabilities; - pain; - skin conditions; - nutritional and hydration status and preferences; - list of treatments, including type, frequency, and level of assistance needed; - nursing needs, including potential to receive nursing-delegated services; - risk indicators; - who has decision-making authority for the resident; and - the need for follow-up referrals for additional	{01620}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 06/12/2025
NAME OF PROVIDER OR SUPPLIER THE JAMES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431			
(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
{01620}	Continued From page 5 medical or cognitive care by health professionals. R2 R2 was admitted May 4, 2018, and had diagnoses including bipolar affective disorder (a mental health disorder causing extreme mood shifts), major neurocognitive disorder (a decline in mental function), and polysubstance abuse (the use of more than one drug). R2's Service Plan / 90-day Monitoring / reassessment form dated April 21, 2025, indicated R2 received services including assistance with medication administration. R2's record lacked a comprehensive assessment conducted by a RN, that addressed the content required in the uniform assessment tool, as identified in Minnesota Rules chapter 4659.0150. R3 R3 was admitted November 25, 2022, and had diagnoses including schizophrenia (a serious mental health disorder that affects how people think, feel, and behave), and major depressive disorder. R3's Service Plan / 90-day Monitoring / reassessment form dated April 21, 2025, indicated R3 received services including assistance with laundry, bathing, dressing, grooming, toileting, transfers, mobility, and medication administration. R3's record lacked a comprehensive assessment conducted by a RN, that addressed the content required in the uniform assessment tool, as identified in Minnesota Rules chapter 4659.0150. R4	{01620}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 06/12/2025
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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
{01620}	Continued From page 6 R4 was admitted April 3, 2015, and had diagnoses including schizoaffective disorder (a chronic mental illness), cognitive impairment, and type two diabetes (insulin resistance). R4's Service Plan / 90-day Monitoring / reassessment form dated April 21, 2025, indicated R4 received services including assistance with behavior management, bathing, laundry, and medication administration. R4's record lacked a comprehensive assessment conducted by a RN, that addressed the content required in the uniform assessment tool, as identified in Minnesota Rules chapter 4659.0150. R5 R5 was admitted on February 19, 2016, and had diagnosis including schizophrenia. R5's Service Plan / 90-day Monitoring / reassessment form dated April 21, 2025, indicated R5 received services including assistance with behavior management, bathing, laundry, and medication administration. R5's record lacked a comprehensive assessment conducted by a RN which addressed the required uniform assessment tool content as identified in Minnesota Rules chapter 4659.0150. The licensee's Correction Order Response - [licensee] signed April 12, 2025, read under the section titled Tag #1620 - 144G.70 Subd. 2(c-e): Missing nursing assessments, "Completed 14-day and 90-day reassessment for all residents using the state-mandated assessment tool." On June 11, 2025, at 12:24 p.m., clinical nurse supervisor (CNS)-B stated they were unable to	{01620}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 06/12/2025
NAME OF PROVIDER OR SUPPLIER THE JAMES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431			
(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
{01620}	Continued From page 7 locate each resident's most recent assessment in their respective charts. CNS-B stated they would contact LALD/RN-A to review records stored offsite for the requested assessments but were unsure why each resident's assessment was not maintained in the resident records. The licensee's 6.01 Assessment, Reviews & Monitoring policy dated January 14, 2025, indicated licensee's assessments would include all required content as indicated on the uniform assessment tool per Minnesota Rules chapter 4659.0150. No additional information was provided.	{01620}			
{03090} SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the required notice, including statutory language to disclose potential electronic monitoring activity, was posted at the main entry way of the facility. This had the potential to affect all current residents, staff, and any visitors to the facility. This practice resulted in a level one violation (a violation that has not potential to cause more than	{03090}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 06/12/2025
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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
{03090}	Continued From page 8 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: On June 11, 2025, at 12:00 p.m., the surveyor approached licensee's facility and noted no electronic monitoring notice posted at any entrance surveyor noted from the front of the building. Upon entering facility, no electronic monitoring notice was noted to be posted inside the building, near the entrance. On June 11, 2025, at 12:24 p.m., clinical nurse supervisor (CNS)-B stated electronic notice should be posted at the primary entrance to the facility. CNS-B stated licensee would need to create and post the notice. The licensee's 2.15 Electronic Monitoring policy dated June 2021, indicated "1. Signs are installed at each facility entrance accessible to visitors that state: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons or activities." No further information was provided.	{03090}			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

May 8, 2025

Licensee

The James Inc

10549 Beard Avenue South

Bloomington, MN 55431

RE: Project Number(s) SL28558016

Dear Licensee:

On April 9, 2025, 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 November 14, 2024. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the November 14, 2024 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on November 14, 2024, found not corrected at the time of the April 9, 2025, follow-up survey and/or subject to penalty assessment are as follows:

0580-Quality Management-144g.42 Subd. 2 - \$500.00

0630-Compliance With Requirements For Reporting Ma-144g.42 Subd. 6 (b)

0680-Disaster Planning And Emergency Preparedness-144g.42 Subd. 10 - \$500.00

0780-Fire Protection And Physical Environment-144g.45 Subd. 2 (a) (1) - \$3,000.00

1440-Supervision Of Staff Providing Delegated Nurs-144g.62 Subd. 4

1620-Initial Reviews, Assessments, And Monitoring-144g.70 Subd. 2 (c-E) - \$500.00

1650-Service Plan, Implementation And Revisions To-144g.70 Subd. 4 (f)

3090-Notice To Visitors-144.6502, Subd. 8

The details of the violations noted at the time of this follow-up survey completed on April 9, 2025 (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 April 9, 2025, we identified the following violation(s):

0340-Correction Orders-144g.30 Subd. 5- \$3000.00

1880-Storage Of Medications-144g.71 Subd. 19

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 \$7,500.00**. 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 Renee L. Anderson at 651-201-5871.

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 cursive script that reads "Renee L. Anderson". The signature is written in dark ink on a light background.

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

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 04/09/2025
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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 FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SL#28558016-1 On April 9, 2025, 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 November 14, 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 issued and/or 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=I	144G.30 Subd. 5 Correction orders (a) A correction order may be issued whenever	0 340			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 04/09/2025
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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
0 340	Continued From page 1 the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, an agent of the facility, or staff 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: (1) 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; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to record actions taken to comply with all correction orders from a survey completed November 14, 2024. The lack of action to ensure compliance with state statutes had the potential to affect all residents staff and visitors. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to	0 340			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 04/09/2025
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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
0 340	Continued From page 2 serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The result of the licensee's previous survey, concluded on November 14, 2024, was sent to the licensee via email on March 13, 2025. The longest time period for correction (the time frame in which the licensee must document and correct orders) was 21 days from the date the licensee received their results, or April 3, 2025. On April 9, 2025, at 11:50 a.m., licensed assisted living director/registered nurse (LALD/RN)-A provided the surveyor with documented corrective actions which included corrective measures taken regarding medication administration, and a service plan development process. The licensee also provided a previously submitted plan created to mitigate the immediate risk of an order issued November 13, 2024, for improper disposal of smoking materials and smoking in the facility. The plan did not indicate whether proposed actions were completed, dates completed, or identification of staff or residents involved. The licensee lacked documented corrective actions from the survey completed November 14, 2024, for the following orders: -0580, 144G.42 Subd, 2. Quality Management; -0630, 144G.42 Subd. 6. (b) Compliance with requirements for reporting maltreatment of vulnerable adults; abuse prevention plan; -0680, 144G.42 Subd. 10. Disaster planning and	0 340			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 04/09/2025
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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	
0 340	Continued From page 3 emergency preparedness plan; -0780, Minnesota State Fire Code, Minnesota Rules 7511; -1440, 144G.62 Subd. 4. Supervision of staff providing delegated nursing or therapy tasks; -1620, 144G.70 Subd. 2. (c) Initial reviews, assessments, and monitoring; and -3090, 144.6502 Subd. 8. Notice to Visitors. The above-listed correction orders were found to be not corrected, and were re-issued on the follow-up survey. On April 9, 2025, at 11:59 a.m., LALD/RN-A stated he had no additional correction documentation to provide the surveyor. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 340			
{0 480} SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part	{0 480}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 04/09/2025
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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
{0 480}	Continued From page 4 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by:	{0 480}			
			Not reviewed during this follow up survey.		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 04/09/2025
NAME OF PROVIDER OR SUPPLIER THE JAMES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431			
(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
{0 480}	Continued From page 5	{0 480}			
{0 580} SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to implement and maintain a quality management program appropriate to the size of the facility and relevant to the type of services provided. This had the potential to affect all 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). The findings include: On April 9, 2025, at 9:40 a.m., during the follow	{0 580}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 04/09/2025
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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
{0 580}	Continued From page 6 up survey introduction, the surveyor requested to review the licensee's current quality management plan. On April 9, 2025, at 11:50 a.m., licensed assisted living director/registered nurse (LALD/RN)-A stated he thought he provided the quality management meeting information to the surveyor during the last survey but maybe it was an old meeting. LALD/RN-A verbalized he was not able to find any evidence of a documented quality management meeting completed in the last 12 months. The licensee's undated 2.31 Quality Management Project policy indicated "[Licensee] will have at least one documented quality management project in place at all times and retain records of such projects for at least two years." Also, included "6. Document the quality management process; keep all related documents on file for at least two years. 7. The quality management documentation should be made available, upon request, to MDH surveyors and OHFC investigators. 8. At least one performance improvement project needs to be in process at all times." No further information was provided.	{0 580}			
{0 630} SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the	{0 630}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 04/09/2025
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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
{0 630}	Continued From page 7 person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an accurate individual abuse prevention plan (IAPP) was developed to include the required content for one of three residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: R2 was admitted May 4, 2018, and had diagnoses including bipolar affective disorder (a mental health disorder causing extreme mood shifts), major neurocognitive disorder (a decline in mental function), and polysubstance abuse. R2's unsigned Service Plan / 90 day Monitoring / reassessment form dated October 1, 2024, indicated R2 received services including assistance with medication administration. R2's nursing progress note dated November 12, 2024, at 11:40 a.m., indicated "[Surveyor] from dept of health Minnesota question [side rails] in	{0 630}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 04/09/2025
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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
{0 630}	Continued From page 8 resident bed, although is not being used. Staff discussed with resident and call to resident family in taken (sic) the [side rails] off the bed and was agreed upon." A progress note dated November 12, 2024, at 3:30 p.m., indicated maintenance had removed the side rails from R2's bed. During the follow-up survey, on April 9, 2025, at 9:48 a.m., the surveyor observed R2's bedroom with clinical nurse supervisor (CNS)-B, and observed R2's hospital bed had no side rails. CNS-B verbalized they removed the side rails after the last survey because R2 was not using the side rails. R2's record included an undated IAPP. The bottom of the IAPP form included a copywrite date of January 2025. R2's IAPP included a section titled vulnerabilities that included, "Has side rails/bed mobility device(s)" marked as "True". The vulnerability description indicated, "Residents (sic) need staff assistance to transfer in and out of bed." R2's IAPP indicated the following interventions: - "Side rail/ bed positioning device assessment is in place"; - "Side rail/ bed positioning agreement is in place"; - "Safety checks of side rail/ bed positioning device every shift when in use"; and - "Staff to report concerns with side rails/ bed positioning device to nurse promptly". R2's medical record lacked a current and accurate IAPP. On April 9, 2025, at 12:44 p.m., LALD/RN-A and CNS-B stated they had not realized R2's IAPP still contained information that R2 utilized side rails. LALD/RN-A verbalized R2's IAPP would	{0 630}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 04/09/2025
NAME OF PROVIDER OR SUPPLIER THE JAMES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431			
(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
{0 630}	Continued From page 9 need to be updated and corrected. The licensee's Individual Abuse Prevention Plan policy dated June 2021 indicated, "1. The plan will contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including: a. other vulnerable adults b. the person's risk of abusing other vulnerable adults, and c. statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. 2. For purposes of the abuse prevention plan, abuse includes self-abuse." No further information was provided.	{0 630}			
{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}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 04/09/2025
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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
{0 680}	Continued From page 10 received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain a written emergency preparedness (EP) plan with all the required content as defined in the Center for Medicare and Medicaid Services (CMS)Appendix Z. The licensee further failed to post an emergency disaster plan. 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On April 9, 2025, at 9:45 a.m., during a tour of the facility with clinical nurse supervisor (CNS)-B, the surveyor observed the facility lacked a posted EP plan. CNS-B stated she was not sure where the licensee kept the EP plan and asked the surveyor to check with the licensed assisted living director/registered nurse (LALD/RN)-A. The licensee's EP plan dated April 20, 2024, lacked the following: -post an emergency disaster plan prominently; -quarterly review of the missing resident policy;	{0 680}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 04/09/2025
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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
{0 680}	Continued From page 11 and -EP plan testing requirements including an annual full-scale exercise or individual facility-based functional exercise and a second full-scale exercise that was either community-based, an individual facility based functional exercise, a mock disaster drill, or a table-top exercise. On April 9, 2025, at 1:06 p.m., when requested, LALD/RN-A was unable to provide evidence of an annual full-scale exercise or individual facility-based functional exercise and a second full-scale exercise that was either community-based, an individual facility based functional exercise, a mock disaster drill, or a table-top exercise, during the survey. -at 1:16 p.m., LALD/RN-A stated he did not know the EP was to be posted in the facility and the missing resident policy was to be reviewed quarterly. LALD/CNS-A verbalized the licensee did not have documented evidence the missing resident policy was reviewed quarterly. The licensee's 9.01 Emergency Preparedness Plan-Appendix Z Compliance Policy indicated the EP plan would include all the required elements of Appendix Z and would be based on the assisted living and community-based risk assessments, utilizing an all-hazards approach. No further information was provided.	{0 680}			
{0 780} SS=I	144G.45 Subd. 2 (a) (1) Fire protection and physical environment for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes;	{0 780}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 04/09/2025
NAME OF PROVIDER OR SUPPLIER THE JAMES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431			
(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
{0 780}	Continued From page 12 (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: Based on observation and interview, the licensee failed to comply with the smoking requirements under Minnesota State Fire Code, Minnesota Rules 7511. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	{0 780}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 04/09/2025
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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	
{0 780}	Continued From page 13 On April 9, 2025, from approximately 10:47 a.m. to 11:30 a.m., the surveyor toured the facility with clinical nurse supervisor (CNS)-B and observed the following: During the tour, the surveyor observed evidence of improperly disposed of smoking materials with cigarette butts on the ground around the facility. Cigarette butts were improperly disposed of onto rear deck, garage, and onto ground in front and rear yard. The surveyor inquired about the presence of the cigarette butts and CNS-B indicated that they were old and had not been cleaned up. CNS-B stated that residents are instructed to smoke in the street in front of the property and not to smoke on facility grounds and that each resident was provided with a portable ashtray to extinguish smoking materials in. The surveyor requested to view the supplied ashtrays. CNS-B showed several resident rooms to the surveyor, but no ashtrays were present. The surveyor further inquired about smoking during the tour, noting cigarette materials in the garage and other locations to CNS-B. CNS-B stated that smoking is not permitted in the garage and that approved receptacles are provided on the rear porch. The surveyor and CNS-B observed the rear porch and no smoking receptacles were located in the area. The surveyor inquired of resident (R)2 about smoking receptacles. R2 indicated that they do smoke in their resident room, in the front yard and in the rear yard, but that they had not been supplied with an ashtray. R2 stated smoking receptacles had been provided on the rear porch, but had since been removed and not replaced. The nurse evaluator indicated that prior to the engineering surveyor's arrival for the survey, discarded smoking materials had been removed from resident rooms	{0 780}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 04/09/2025
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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	
{0 780}	Continued From page 14 within the facility. Smoke alarms were not properly interconnected. The surveyor requested that CNS-B test the smoke alarms in the facility. CNS-B tested the smoke alarms by pressing the test button on the smoke alarm in the main level resident room hallway and in resident room 2. During testing, only the smoke alarms in the hallway, resident room 1 and resident 2 sounded. The smoke alarms in the basement, the living room, resident 3, resident room 4, and resident 5 did not sound and were not interconnected when tested. CNS-B stated that the smoke alarms had been tested and were properly interconnected the previous week. CNS-B confirmed that the supplied smoke alarms were not interconnected when tested during the survey. Surveyor explained to CNS- B that smoking materials must be properly disposed of in approved noncombustible receptacles and that smoke alarms must be maintained On April 9, 2025, the surveyor explained to CNS-B that an immediate correction order was issued for the above findings. CNS-B stated they understood the requirements for disposal of smoking materials and interconnected smoke alarms.	{0 780}			
{0 800} SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the	{0 800}			

Minnesota Department of Health
STATE FORM 6899 JN9S12 If continuation sheet 16 of 31

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 04/09/2025
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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	
{0 810}	Continued From page 16 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:	{0 810}	Not reviewed during this survey.		
{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 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:	{01440}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 04/09/2025
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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
{01440}	Continued From page 17 Based on interview, and record review, the licensee failed to ensure a registered nurse (RN) conducted direct supervision of staff performing a delegated task within 30 days of providing services for two of two employees (unlicensed personnel (ULP)-C, ULP-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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-C and ULP-D were hired June 2, 2023, and December 4, 2023, respectively, and provided direct care services for residents of the facility. On April 9, 2025, at 10:29 a.m., clinical nurse supervisor (CNS)-B stated both ULP-C and ULP-D administered medications to the residents after CNS-B completed their training, upon hire. ULP-C and ULP-D's employee records included a 30-day Staff Performance Review form dated June 1, 2023, and December 23, 2024, but lacked evidence the RN conducted direct supervision of the employee performing a delegated task within 30 days after the employee had first performed the delegated task for residents. On April 9, 2025, at 10:35 a.m., CNS-B stated she was not aware a 30-day supervision of a delegated task was to be documented in ULP-C	{01440}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 04/09/2025
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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
{01440}	Continued From page 18 and ULP-D's employee record and thought the performance review may suffice. The surveyor provided education to CNS-B on the requirement of 30-day supervision of a delegated task. The licensee's 6.17 Supervision of Staff - Delegated Services dated June 1, 2021, included "1. Direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for [Licensee] and first performs the delegated tasks for residents and thereafter as needed based on performance." No further information was provided.	{01440}			
{01620} SS=F	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 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	{01620}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 04/09/2025
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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
{01620}	Continued From page 19 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 observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident monitoring and reassessment, utilizing a uniform assessment tool, not to exceed 90 days from the previous assessment for three of three residents (R2, R3, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On April 9, 2025, at 11:30 a.m., the surveyor observed clinical nurse supervisor (CNS)-B assist R4 with blood glucose testing. R2 R2 was admitted May 4, 2018, and had diagnoses including bipolar affective disorder (a mental health disorder causing extreme mood shifts), major neurocognitive disorder (a decline in mental function), and polysubstance abuse (the use of more than one drug). R2's unsigned Service Plan / 90-day Monitoring / reassessment form dated October 1, 2024,	{01620}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 04/09/2025
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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
{01620}	Continued From page 20 indicated R2 received services including assistance with medication administration. R2's medical record included an initial assessment dated May 4, 2018, but lacked subsequent 90-day comprehensive nursing assessments utilizing a uniform assessment tool with the required assessment tool elements as identified in Minnesota Rules chapter 4659.0150. R3 R3 was admitted November 25, 2022, and had diagnoses including schizophrenia (a serious mental health disorder that affects how people think, feel, and behave), and major depressive disorder. R3's Service Plan dated October 21, 2021, indicated R3 received services including assistance with laundry, bathing, dressing, grooming, toileting, transfers, mobility, and medication administration. R3's medical record lacked an initial, 14-day and any subsequent 90-day comprehensive nursing assessments utilizing a uniform assessment tool with the required assessment tool elements as identified in Minnesota Rules chapter 4659.0150. R4 R4 was admitted April 3, 2015, and had diagnoses including schizoaffective disorder (a chronic mental illness), cognitive impairment, and type two diabetes (insulin resistance). R4's Service Plan, dated November 11, 2018, indicated R4 received services including assistance with behavior management, bathing, laundry, and medication administration.	{01620}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 04/09/2025
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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
{01620}	Continued From page 21 R4's medical record included an initial assessment dated November 25, 2014, but lacked a 14-day assessment and subsequent 90-day comprehensive nursing assessments utilizing a uniform assessment tool with the required assessment tool elements as identified in Minnesota Rules chapter 4659.0150. On April 9, 2025, at 12:38 p.m., licensed assisted living director/registered nurse (LALD/RN)-A and CNS-B stated they thought the licensee's document titled Service Plan/90 day Monitoring/reassessment form could be used for an assessment. LALD/RN-A and CNS-B stated they were not aware of the licensee's assessment policy, nor that the forms a nurse could utilize were located in the licensee's policy and procedure manual. The licensee's 6.03 Uniform Assessment Tool policy dated June 2021, included "[Licensee] will use a uniform assessment tool that addresses all of the required elements." The licensee's 6.01 Assessments, Reviews, and Monitoring policy, dated June 2021, indicated "1. The initial nursing assessment or reassessment must include all the elements of the uniform assessment tool as required, conducted in person (unless see #2), be in writing, dated, and signed by the registered nurse who conducted the assessment. 2. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. 3. Resident reassessment and monitoring must be conducted	{01620}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 04/09/2025
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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	
{01620}	Continued From page 22 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." No additional information was provided.	{01620}			
{01650} SS=E	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those	{01650}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 04/09/2025
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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
{01650}	Continued From page 23 chapters. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to ensure the service plan included the required content for two of three residents (R2, 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 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: R2 R2 was admitted May 4, 2018, and had diagnoses including bipolar affective disorder (a mental health disorder causing extreme mood shifts), major neurocognitive disorder (a decline in mental function), and polysubstance abuse. R2's undated and unsigned Service Plan Agreement indicated R2 received services including assistance with medication administration. In addition to lacking the resident's signature, R2's service plan lacked the following: -a contingency plan that includes: -the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has	{01650}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 04/09/2025
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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
{01650}	Continued From page 24 authority to sign for the resident in an emergency. R3 R3 was admitted November 25, 2022, and had diagnoses including schizophrenia (a serious mental health disorder that affects how people think, feel, and behave) and major depressive disorder. R3's undated, and unsigned Service Plan indicated R3 received services including assistance with behavior management, toileting, and medication administration. In addition to lacking the resident's signature, R3's service plan lacked the following required content: -a contingency plan that includes: -the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and -the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. On April 9, 2025, at 1:20 p.m., licensed assisted living director/registered nurse (LALD/RN)-A stated he must have missed completing all of the required service plan content for R2 and R3. The licensee's 6.08 Service Plan policy dated June 2021, included, 9. A service plan will include: a. A description of the services that are to be provided based on the most recent assessment and resident preferences; b. Fees for services to be provided;	{01650}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 04/09/2025
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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
{01650}	Continued From page 25 c. The frequency of each service to be provided based on the most recent assessment and resident preferences; d. An identification of staff or categories of staff who will be providing services (RN, LPN, unlicensed personnel, etc.); e. A schedule and method for the next planned assessment or monitoring; and f. A schedule and method for the next planned monitoring of staff providing services. g. A contingency plan that includes: i. Actions [Licensee] will take if scheduled services cannot be provided ii. Information regarding how the resident can contact [Licensee] iii. The names and contact information the resident wishes, if any, to have notified in an emergency or if there is a significant adverse change in the resident's condition iv. Identification and contact information of who the resident has authorized, if any, to sign for the resident in an emergency v. How the facility will support documented resident health care directive decisions, if any - including circumstances when emergency medical services are not to be summoned. The policy further indicated, "Other optional documents such as "care plans", "assignment sheets", or other internal documents may be used to assist staff in understanding their daily assignments and tasks, but such documents are not required and do not replace the required service plan." No further information was provided.	{01650}			
01880 SS=D	144G.71 Subd. 19 Storage of medications An assisted living facility must store all	01880			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 04/09/2025
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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
01880	Continued From page 26 prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were stored in securely locked and substantially constructed compartments, according to manufacturer's instructions, for one refrigerator where unopened insulin was stored. 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: On April 9, 2025, at 11:40 a.m., the surveyor observed the main food refrigerator in the kitchen of the facility with clinical nurse supervisor (CNS)-B. The kitchen refrigerator was unlocked and contained three unopened boxes of Basaglar (long-acting insulin, for diabetes) insulin pens, and three unopened insulin lispro (fast-acting insulin) pens. The refrigerator had a thermometer, but the licensee lacked a temperature log to document that the refrigerator was maintained within the manufacturer recommended temperature range for refrigerated storage of medications. CNS-B stated this was where the licensee typically stored the residents	01880			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 04/09/2025
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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
01880	Continued From page 27 unopened insulin. Manufacturer directions for Basaglar insulin and insulin lispro dated, September 14, 2022, and July 2023, respectively, indicated to store unopened pens under refrigeration at 2° to 8° C [Celsius] (36° to 46° F [Fahrenheit]). On April 9, 2025, at 11:45 a.m., CNS-B stated the licensee did not document the refrigerator temperatures. CNS-B stated the residents did have access to the kitchen refrigerator, and the insulin was not kept locked inside the refrigerator. CNS-B further stated they were not aware the insulin should be secured. CNS-B verbalized she would implement a process to secure refrigerated medications and document monitoring of the refrigerator temperatures where unopened insulin was stored. The licensee's 7.11 Medication Storage policy, dated June 2021, indicated, "When medications are managed and stored by [Licensee], medications will be kept securely locked and stored per manufacturer's directions. Only authorized staff will have access to stored medications." In addition, included, "Medications managed by [Licensee] will be stored to prevent diversion of medications by residents or others who may have access to the medications. Diversion means the misuse, theft, or illegal or improper dispositions of medications. Medications managed outside of a resident's private "living space" must be in securely locked and substantially constructed compartments and permit only authorized personnel to have access. This may be a medication room, medication cart, or similar setup. Medications will be stored consistent with manufacturer's recommendations (refrigerated,	01880			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 04/09/2025
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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	
01880	Continued From page 28 room temperature, or frozen). No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880			
{01910} SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by:	{01910}			
{03090} SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states:	{03090}	Not reviewed during this follow up survey.		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 04/09/2025
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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
{03090}	Continued From page 29 "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the required notice, including statutory language to disclose potential electronic monitoring activity, was posted at the main entry way of the facility. This had the potential to affect all current residents, staff, and any visitors to the facility. This practice resulted in a level one violation (a violation that has not potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On April 9, 2025, at 9:40 a.m., upon entrance to the facility, the surveyor observed the licensee lacked an electronic monitoring notice with the required statutory language. On April 9, 2025, at 12:59 p.m., licensed assisted living director/registered nurse (LALD/RN)-A stated he thought if the licensee did not have any electronic monitoring in place the notice was not required to be posted. The surveyor provided education to the LALD/RN-A on the electronic monitoring posting requirement.	{03090}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 04/09/2025
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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
{03090}	Continued From page 30 The licensee's 2.15 Electronic Monitoring policy dated June 2021, indicated "1. Signs are installed at each facility entrance accessible to visitors that state: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons or activities." No further information was provided.	{03090}			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

March 13, 2025

Licensee

The James Inc.

10549 Beard Avenue South

Bloomington, MN 55431

RE: Project Number(s) SL28558016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on November 14, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement.

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;

Level 3: a fine of \$3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.

Level 4: a fine of \$5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

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

0780 - 144g.45 Subd. 2 (a) (1) - Fire Protection And Physical Environment - \$3,000.00
2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - \$3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$6,000.00.** You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by 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.

INFORMAL CONFERENCE

In accordance with Minn. Stat. § 144G.20, Subd. 20, the Commissioner of Health is authorized to hold a conference to exchange information, clarify issues, or resolve issues. The Department of Health staff would like to schedule a conference call with The James Inc. Please contact Renee Anderson at 651-201-5871 on or before Tuesday, March 18, 2025, to schedule the conference call.

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,

A handwritten signature in cursive script that reads "Renee L. Anderson".

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

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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 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: SL28558016-0 On November 12, 2024, through November 14, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were four residents; four receiving services under the Assisted Living Facility license. An immediate correction order was issued November 12, 2024, for tag identification 2310. The licensee failed to submit a complete plan of correction; the scope and severity remain at level 3, widespread. An immediate correction order was issued on November 13, 2024, for tag identification 0780. During the course of the survey, the licensee took action to mitigate the immediate risk. Noncompliance remained and the scope and level remain unchanged.	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.		

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431			
(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
0 450	Continued From page 1	0 450			
0 450 SS=F	144G.41 Subdivision 1 Minimum requirements All assisted living facilities shall: (1) distribute to residents the assisted living bill of rights; (2) provide services in a manner that complies with the Nurse Practice Act in sections 148.171 to 148.285; (3) utilize a person-centered planning and service delivery process; (4) have and maintain a system for delegation of health care activities to unlicensed personnel by a registered nurse, including supervision and evaluation of the delegated activities as required by the Nurse Practice Act in sections 148.171 to 148.285; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide services in a person-centered planning and service delivery process for three of three residents (R2, R3, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On November 12, 2024, through November 14, 2024, the surveyor observed the residents and staff during the survey. R2	0 450			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431			
(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
0 450	Continued From page 2 R2 had diagnoses including bipolar affective disorder (a mental health disorder causing extreme mood shifts), major neurocognitive disorder (a decline in mental function), and polysubstance abuse. R2's Service Plan Agreement dated May 4, 2018, completed over six years ago, indicated R2 needed assistance with meals, housekeeping, bathing, grooming, and medication administration. The Service Plan Agreement further indicated the licensee's Monthly Service Package offered to R2 included, "Unscheduled redirection or intervention to address inappropriate client behavior." The inappropriate behavior included, "physical or verbal aggression directed toward self, or person residing at, working in, or a guest of, [Licensee]". R2's Client Initial Assessment, dated May 4, 2018, indicated R2 required intervention assistance with personal cares, dressing, toileting, bathing, meals, laundry, and special instructions of "Anticipate needs. Resident have difficulty - commucatig [sic]." No further comprehensive assessments were available. R2's medical record included an undated Care Plan for behaviors with a focus on alteration in mood and or behavior patterns with physical aggression indicated with an "X." R2's individual abuse prevention plan (IAPP) dated May 4, 2018, indicated R2 exhibited verbal aggression toward others, "destroys property", "steals property", and "provokes others". R2's IAPP lacked any updated person-centered interventions since the initial plan was developed. R2's most recent nursing progress note dated	0 450			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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
0 450	Continued From page 3 December 16, 2023, indicated "staff was given (sic) resident his medication when the resident hit the staff for no reason juice and medications spill all over the floor." No follow-up nursing note or added interventions were documented. R2's medical record lacked: -a current IAPP with person-centered behavior management interventions to instruct staff on how to handle behaviors; and -current service plan which indicated provision of person-centered behavior management services. R3 R3 had diagnoses including schizophrenia (a serious mental health disorder that affects how people think, feel, and behave) and major depressive disorder. R3's undated, and unsigned Service Plan indicated R3 received services including assistance with toileting, medication administration, and management of behaviors every shift, including agitation, wandering, elopement, property destruction, physical aggression, verbal aggression, "orientation to issues", anxiety, self-injurious and repetitive behavior. The services were indicated to be provided by both the unlicensed personnel (ULP) and the registered nurse (RN). R3's record included an undated IAPP. The IAPP lacked R3's name anywhere on the document. The IAPP indicated, "resident at risk of abusing other vulnerable adults" and "resident at risk of self abuse", both marked as "false". No person-centered interventions or outcomes were noted for these areas. R3's nursing progress note, dated January 26,	0 450			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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
0 450	Continued From page 4 2023, indicated R3 was uncooperative at a medical appointment, and when staff attempted to intervene, R3, "walk to the staff and hit a big blow over to (sic) the staff [left] ear resulting to (sic) commotion and the resident was sent to a psychiatry ward for hospitalization." -R3's most recent nursing progress note dated January 24, 2024, indicated "staff took resident to the clinic, resident was fighting with the resident and others & management [illegible]" R3's medical record lacked: -a completed IAPP with interventions for staff to follow to prevent abuse; -current and ongoing comprehensive nursing assessments; and -a nursing follow-up to the progress notes dated January 26, 2023, and January 24, 2024, including reassessment with updated person-centered behavior management and interventions subsequent to the clinic visit. R4 R4 had diagnoses including schizoaffective disorder (a chronic mental illness), cognitive impairment, and type two diabetes (insulin resistance). R4's Service Plan, dated November 11, 2018, indicated R4 received services including assistance with bathing, laundry, medication administration, and behavior management. R4's care plan, dated November 29, 2018, indicated behavior interventions for verbal aggression, including approaching resident in a calm manner, removing harmful objects from the vicinity, explaining procedures before initiating, refraining from arguing with resident, rewarding appropriate behavior with praise, administering as	0 450			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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
0 450	Continued From page 5 needed medications and notifying the medical provider for new behaviors. R4's medical record included a Behavior Monitoring Form dated November 2024 and December 2024, indicating behavior management interventions on all shifts utilizing intervention outcome and side effect codes. The form lacked indication what target behavior was being addressed. R4's record included a nurses progress note, dated October 4, 2023, that indicated, "staff reported that resident grab (sic) a knife in the kitchen, attempt to use it on the staff, then the staff call the police and came then took the resident away to HCMC ER for evaluation." -A progress note dated October 27, 2023, indicated R2, "return from HCMC psych with [diagnosis] of paranoid schizophrenia with delusional thought". R4's medical record lacked: -a completed, current IAPP with interventions for staff to follow to prevent abuse; -current and ongoing comprehensive nursing assessments; and -a nursing follow-up to the progress notes dated October 27, 2023, including reassessment with updated person-centered behavior management and interventions subsequent to the clinic visit. On November 12, 2024, at 11:35 a.m., licensed assisted living director/registered nurse (LALD/RN)-A and clinical nurse supervisor (CNS)-B verbalized they had tried everything, do the best they can, and the behaviors and residents were very hard to manage. On November 13, 2024, at 7:33 a.m., the	0 450			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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
0 450	Continued From page 6 surveyor observed R5 slap CNS-B on the hand. CNS-B stated "stop, that is not okay." R5 verbalized to CNS-B she should not touch anything in his room. CNS-B verbalized to the surveyor it was very difficult to care for the residents at times due to the behaviors they dealt with. On November 13, 2024, at 7:45 a.m., ULP-C stated it could be really hard to handle the behaviors of the residents. ULP-C verbalized she updated the nurse when there were resident behavior concerns. ULP-C stated she had resident care experience but did not indicate if her experience included residents with mental health diagnoses. On November 14, 2024, at 10:00 a.m., CNS-B stated she was not aware a current IAPP with the required content was not completed for R3 or R4 and was not sure where the documentation would be located, but that she would make sure all the residents had a current IAPP which included all the required content with specific interventions. Also, CNS-B verbalized she had not updated R2, R3, and R4's resident care plans with current person-centered interventions as required. The licensee's 6.14 Delegation of Assisted Living Services policy dated June 2021, indicated "A registered nurse or licensed health professional at [Licensee] may delegate tasks only to staff who are competent and possess the knowledge and skills consistent with the complexity of the tasks and according to the appropriate Minnesota practice act. The facility will establish and implement a system to communicate up-to-date information to the registered nurse or licensed health professional regarding the current available staff and their competency so the	0 450			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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
0 450	Continued From page 7 registered nurse or licensed health professional has sufficient information to determine the appropriateness of delegating tasks to meet individual resident needs and preferences." The licensee's 6.19 Resident Change in Condition or Need policy dated June 2021, indicated "[Licensee] will conduct initial reviews and scheduled assessments and monitoring as required. And, when changes in condition or need are identified, a Registered Nurse will initiate a change in condition assessment. The assessment may be limited to only those issues where a change has been identified." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 450			
0 460 SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before	0 460			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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
0 460	Continued From page 8 entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide a means for residents to request assistance for health and safety needs 24 hours a day, seven days a week for three of four residents (R2, R3, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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: R2 R2 had diagnoses including bipolar affective disorder (a mental health disorder causing extreme mood shifts), major neurocognitive disorder (a decline in mental function), and polysubstance abuse. R2's undated and unsigned Service Plan Agreement indicated R2 needed assistance with medication administration. R2's Client Initial Assessment, dated May 4, 2018, indicated R2 required intervention assistance with personal cares, dressing, toileting, bathing, meals, laundry, and special instructions of "Anticipate needs. Resident have difficulty - commucatig [sic]." The record lacked a	0 460			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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
0 460	Continued From page 9 current comprehensive nursing assessment. R3 R3 had diagnoses including schizophrenia (a serious mental health disorder that affects how people think, feel, and behave) and major depressive disorder. R3's undated, and unsigned Service Plan indicated R3 needed assistance with behavior management, toileting, and medication administration. R3's medical record lacked an initial comprehensive nursing assessment. R4 R4 had diagnoses including schizoaffective disorder (a chronic mental illness), cognitive impairment, and type two diabetes (insulin resistance). R4's Service Plan, dated November 11, 2018, indicated R4 received services including assistance with behavior management, bathing, laundry, and medication administration. R4's Client Initial Assessment, dated November 25, 2014, indicated R4 required intervention assistance with personal cares, dressing, toileting, bathing, meals, laundry, medication administration, and special instructions of "Give less sugar." The record lacked a current comprehensive nursing assessment. On November 12, 2024, at 10:10 a.m., unlicensed personnel (ULP)-C stated she would check in on the residents in their bedrooms, but did not indicate a time or frequency for completing the resident checks.	0 460			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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
0 460	Continued From page 10 On November 12, 2024, at 10:30 a.m., during the entrance conference, licensed assisted living director/registered nurse (LALD/RN)-A stated the residents could "yell out" to summon assistance. LALD/RN-A also verbalized an employee was always here at the facility and available to assist a resident as needed. On November 14, 2024, at 9:30 a.m., clinical nurse supervisor (CNS)-B stated the residents used to have a bell in each of their bedrooms to call for help. Also, CNS-B verbalized the bells were thrown away by the residents. On November 14, 2024, at 11:45 a.m., R4 was observed to be walking around the main common area of the facility. R4 stated he did not have a call button or phone, but if he needed help, he would, "just go ask them". No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 460			
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; (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	0 470			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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
0 470	Continued From page 11 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 staffing plan was evaluated at least twice a year and the 24-hour staffing schedule was posted in a central location as required. This had the potential to affect the residents, staff, and visitors of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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). The findings include:	0 470			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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
0 470	Continued From page 12 On November 12, 2024, at 10:03 a.m., the surveyor observed the main areas of the facility with unlicensed personnel (ULP)-C. The facility lacked a posting of the daily staff schedule. On November 12, 2024, at 10:30 a.m., after the entrance conference, the surveyor requested to see the licensee's current staffing plan. On November 12, 2024, at 1:00 p.m., licensed assisted living director/registered nurse (LALD/RN)-A stated he thought the staffing plan was at the office and planned to bring it to the survey. On November 13, 2024, at 9:11 a.m., LALD/RN-A provided the surveyor with an undated [Licensee] Contingency Staffing Plan. The contingency staffing plan indicated the number of employees required during non-emergency normal conditions. The staffing plan indicated the licensee would have two employees on the morning shift, two employees on the evening shift, and one employee on the night shift. LALD/RN-A verbalized the licensee staffed the facility with one employee per shift. Finally, LALD/RN-A stated the licensee was unable to afford two employees on day and evening shift. In addition, LALD/RN-A verbalized the licensee would get a daily staff schedule posted. -at 9:30 a.m., clinical nurse supervisor (CNS)-B posted the daily staff schedule next to the bulletin board in the kitchen area. CNS-B verbalized this daily staffing schedule would be updated each day. The licensee's 4.06 Staffing & Scheduling policy dated June 2021, included "1. The clinical nurse supervisor will develop and implement a written staffing plan that provides an adequate number of	0 470			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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
0 470	Continued From page 13 qualified direct-care staff to meet the residents' needs 24-hours a day, seven-days a week." Also, 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. The facility shall not disclose any information that is protected by law from public disclosure." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470			
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570;	0 480			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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
0 480	Continued From page 14 (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a	0 480			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431			
(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
0 480	Continued From page 15 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated November 13, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			
0 500 SS=F	144G.41 Subd. 2 Policies and procedures Each assisted living facility must have policies and procedures in place to address the following and keep them current: (1) requirements in section 626.557, reporting of maltreatment of vulnerable adults; (2) conducting and handling background studies on employees; (3) orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; (4) handling complaints regarding staff or services provided by staff; (5) conducting initial evaluations of residents' needs and the providers' ability to provide those services; (6) conducting initial and ongoing resident evaluations and assessments of resident needs,	0 500			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431			
(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
0 500	Continued From page 16 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; (7) orientation to and implementation of the assisted living bill of rights; (8) infection control practices; (9) reminders for medications, treatments, or exercises, if provided; (10) 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; (11) ensuring that nurses and licensed health professionals have current and valid licenses to practice; (12) medication and treatment management; (13) delegation of tasks by registered nurses or licensed health professionals; (14) supervision of registered nurses and licensed health professionals; and (15) supervision of unlicensed personnel performing delegated tasks. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to show they had met the requirements of licensure, by attesting the managerial officials who were in charge of the day-to-day operations, had developed and implemented current policies and procedures, 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	0 500			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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
0 500	Continued From page 17 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: The licensee began providing Assisted Living services on August 1, 2021. During an entrance conference on November 12, 2024, at 10:30 a.m., licensed assisted living director/registered nurse (LALD/RN)-A, stated he was aware of the current minimum assisted living regulations and requirements of 144G.41. During the survey, from November 12, 2024 through November 14, 2024, the surveyor observed the licensee and employees providing assisted living services to residents. The licensee failed to implement policies and procedures to address the following: Requirements in section 626.557, reporting of maltreatment of vulnerable adults -Refer to licensing order 0630, at MN Statute 144G.42 Subd. 6. (b). The licensee failed to develop and implement an individual abuse prevention plan for each vulnerable adult; and failed to reassess and update the plan as needed; for three of three residents (R2, R3, R4); and -Refer to licensing order 0640, at MN Statute 144G.42 Subd. 7. The licensee failed to support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult	0 500			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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
0 500	Continued From page 18 maltreatment by posting the required information. Orientation, training, and competency evaluations of staff, and a process for evaluating staff performance -Refer to licensing order 1470, at MN Statute 144G.63 Subd. 2. The licensee failed to ensure orientation was completed including all required content, before working with residents, for one of two employees (clinical nurse supervisor (CNS)-B); and -Refer to licensing order 1530, at MN Statute 144G.64 (a) (1-2). The licensee failed to ensure supervisors and direct-care staff completed the required amount of dementia care training within the required timeframe for two of two employees (CNS-B and ULP-C). Conducting initial and ongoing resident evaluations and assessments -Refer to licensing order 1620, at MN Statute 144G.70 Subd. 2. The licensee failed to document an initial comprehensive nursing assessment for one of three residents (R3), and failed to complete a 14 day assessment and subsequent 90 day comprehensive nursing assessments utilizing a uniform assessment tool; for three of three residents (R2, R3, R4). Medication and treatment management -Refer to licensing order 1710, at MN Statute 144G.71 Subd. 3. The licensee failed to monitor and reassess the resident's medication management services for three of three residents (R2, R3, R4); -Refer to licensing order 1730, at MN Statute 144G.71 Subd. 5. The licensee failed to complete an individualized medication management plan	0 500			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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
0 500	Continued From page 19 for three of three residents (R2, R3, R4); -Refer to licensing order 1760, at MN Statute 144G.71 Subd. 8. The licensee failed to 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 for one of two residents (R2); -Refer to licensing order 1820, at MN Statute 144G.71 Subd. 13. The licensee failed to ensure there was a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for two of three residents (R2, R4); -Refer to licensing order 1910, at MN Statute 144G.71 Subd. 22. The licensee failed, upon disposition, to document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, and names of staff and other individuals involved in the disposition for one of one resident (R1); -Refer to licensing order 1940, at MN Statute 144G.72 Subd. 3. The licensee failed to complete an individualized medication management plan for one of three residents (R4); and -Refer to licensing order 1970, at MN Statute 144G.72 Subd. 6. The licensee failed to ensure there was an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies, for one of three residents (R4).	0 500			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431			
(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
0 500	Continued From page 20 Delegation of tasks by registered nurses or licensed health professionals -Refer to licensing order 1950, at MN Statute 144G.72 Subd. 4. The licensee failed to ensure the licensed health professional delegated tasks according to the appropriate practice standards for delegation for one of one employee (ULP-C). Supervision of unlicensed personnel performing delegated tasks -Refer to licensing order 1440, at MN Statute 144G.62 Subd. 4. The licensee failed to perform direct supervision of staff performing delegated tasks within 30 calendar days after the date on which the individual first performed the delegated tasks for one of one unlicensed staff (ULP-C). On November 13, 2024, at 8:45 a.m., the surveyor showed LALD/RN-A and CNS-B the licensee's policy and procedure manual. CNS-B stated she was not aware policies including assessment policies, medication and treatment management policies, and forms the nurse could utilize were in the licensee's policy and procedure manual. The licensee's 7.00 Medication Management Services Required Policies policy dated June 202, included "An assisted living facility that provides medication management services must develop, implement, and maintain current written medication management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse, licensed health professional, or pharmacist consistent with current practice standards and guidelines." The licensee's 7.00 a. Treatment and Therapy Management Services Required Policies policy	0 500			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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
0 500	Continued From page 21 dated June 2021, included "An assisted living facility that provides treatment and therapy management services must develop, implement, and maintain up-to-date written treatment or therapy management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse or appropriate licensed health professional consistent with current practice standards and guidelines." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 500			
0 570 SS=C	144G.42 Subdivision 1 Display of license The original current license must be displayed at the main entrance of each assisted living facility. The facility must provide a copy of the license to any person who requests it. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to display the original current license at the main entrance of the assisted living facility as required. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 570			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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
0 570	Continued From page 22 The findings include: The licensee held an assisted living license effective March 1, 2024, through February 28, 2025. On November 12, 2024, at 10:03 a.m., during an observation of the entrance and main level of the facility with unlicensed personnel (ULP)-C the licensee lacked a posting of the licensee's assisted living license. ULP-C stated she was not sure where the assisted living license was located. On November 12, 2024, at 10:21 a.m., licensed assisted living director/registered nurse (LALD/RN)-A stated he recently renewed the license and did not have a chance to get it posted. On November 12, 2024, at 11:04 a.m., clinical nurse supervisor (CNS-B) stated the assisted living license was posted but did not know where it went. The licensee's undated 2.04 Assisted Living License and Posting policy included "[Licensee] will maintain a current Assisted Living License issued by the Minnesota Department of Health. The issued license will be posted at the main entrance of the facility." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 570			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431			
(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
0 580	Continued From page 23	0 580			
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. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to implement and maintain a quality management program appropriate to the size of the facility and relevant to the type of services provided. This had the potential to affect all 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). The findings include: On November 12, 2024, at 10:30 a.m., during the entrance conference, the surveyor requested to review the licensee's quality management plan.	0 580			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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
0 580	Continued From page 24 On November 12, 2024, at 11:30 a.m., licensed assisted living director/registered nurse (LALD/RN)-A provided the surveyor with the licensee's documentation of their quality management program meeting. The documentation indicated a focus on infection control, dated June 15, 2023, with a completion date of June 30, 2023. On November 14, 2024, at 10:30 a.m., LALD/RN-A stated he was not able to find any evidence of a more current quality management meeting documentation completed in the last 12 months. The licensee's undated 2.31 Quality Management Project policy indicated "[Licensee] will have at least one documented quality management project in place at all times and retain records of such projects for at least two years." Also, included "6. Document the quality management process; keep all related documents on file for at least two years. 7. The quality management documentation should be made available, upon request, to MDH surveyors and OHFC investigators. 8. At least one performance improvement project needs to be in process at all times." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 580			
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an	0 630			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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
0 630	Continued From page 25 individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for three of three residents (R2, R3, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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: R2 was admitted May 4, 2018, and had diagnoses including bipolar affective disorder (a mental health disorder causing extreme mood shifts), major neurocognitive disorder (a decline in mental function), and polysubstance abuse. R2's Service Plan Agreement last updated May 4, 2018, indicated R2 needed assistance with meals, housekeeping, bathing, grooming, and	0 630			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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
0 630	Continued From page 26 medication administration. The Service Plan Agreement further indicated the licensee's Monthly Service Package offered to R2 included, "Unscheduled redirection or intervention to address inappropriate client behavior." The inappropriate behavior included, "physical or verbal aggression directed toward self, or person residing at, working in, or a guest of, [Licensee]". R2's medical record included an undated Care Plan for behaviors with a focus on alteration in mood and or behavior patterns with physical aggression indicated with an "X." R2's individual abuse prevention plan (IAPP) dated May 4, 2018, indicated R2 exhibited verbal aggression toward others, "destroys property", "steals property", and "provokes others". R2's IAPP lacked any updated interventions since the initial plan was developed. R2's most recent nursing progress note dated December 16, 2023, indicated "staff was given (sic) resident his medication when the resident hit the staff for no reason juice and medications spill all over the floor." R2's medical record lacked: -a current IAPP; -a service plan which indicated provision of behavior management services; -current and ongoing comprehensive nursing assessments; and -a nursing follow-up to the progress note dated December 16, 2023, on behavior management interventions or instruction to staff on how to handle these behaviors. R3 R3 was admitted November 25, 2022, and had	0 630			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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
0 630	Continued From page 27 diagnoses including schizophrenia (a serious mental health disorder that affects how people think, feel, and behave) and major depressive disorder. R3's undated, and unsigned Service Plan indicated R3 received services including assistance with toileting, medication administration, and management of behaviors every shift, including agitation, wandering, elopement, property destruction, physical aggression, verbal aggression, "orientation to issues", anxiety, self-injurious and repetitive behavior. The services were indicated to be provided by both the unlicensed personnel (ULP) and the registered nurse (RN). R3's nursing progress note, dated January 26, 2023, indicated R3 was uncooperative at a medical appointment, and when staff attempted to intervene, R3, "walk to the staff and hit a big blow over to (sic) the staff [left] ear resulting to (sic) commotion and the resident was sent to a psychiatry ward for hospitalization." -R3's most recent nursing progress note dated January 24, 2024, indicated "staff took resident to the clinic, resident was fighting with the resident and others & management [illegible]" R3's record included an undated IAPP. The IAPP lacked R3's name anywhere on the document. The IAPP indicated, "resident at risk of abusing other vulnerable adults" and "resident at risk of self abuse", both marked as "false". No interventions or outcomes were noted for these areas. R3's medical record lacked: -a completed IAPP with interventions for staff to follow to prevent abuse;	0 630			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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
0 630	Continued From page 28 -current and ongoing comprehensive nursing assessments; and -a nursing follow-up to the progress notes dated January 26, 2023, and January 24, 2024, including reassessment with updated behavior management and interventions subsequent to the clinic visit. R4 R4 was admitted April 3, 2015, and had diagnoses including schizoaffective disorder (a chronic mental illness), cognitive impairment, and type two diabetes (insulin resistance). R4's Service Plan, dated November 11, 2018, indicated R4 received services including assistance with bathing, laundry, medication administration, and behavior management. R4's care plan, last updated November 29, 2018, indicated behavior interventions for verbal aggression, including approaching resident in a calm manner, removing harmful objects from the vicinity, explaining procedures before initiating, refraining from arguing with resident, rewarding appropriate behavior with praise, administering as needed medications and notifying the medical provider for new behaviors. R4's record included a nurses progress note, dated October 4, 2023, that indicated, "staff reported that resident grab (sic) a knife in the kitchen, attempt to use it on the staff, then the staff call the police and came then took the resident away to HCMC ER for evaluation." -A progress note dated October 27, 2023, indicated R2, "return from HCMC psych with [diagnosis] of paranoid schizophrenia with delusional thought".	0 630			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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
0 630	Continued From page 29 R4's medical record included a Behavior Monitoring Form dated November 2024 and December 2024, indicating behavior management interventions were completed on all shifts by entering outcome and side effect codes. The form did not indicate what target behavior the employees were intervening or responding to. R4's medical record lacked: -a completed, current IAPP with interventions for staff to follow to prevent abuse; -current and ongoing comprehensive nursing assessments; and -a nursing follow-up to the progress notes dated October 4, 2023, and October 27, 2023, including reassessment with updated behavior management and interventions subsequent to the clinic visit. On November 12, 2024, at 11:35 a.m., licensed assisted living director/registered nurse (LALD/RN)-A and clinical nurse supervisor (CNS)-B verbalized they had tried everything, do the best they can, and the behaviors and residents were very hard to manage. On November 13, 2024, at 7:33 a.m., the surveyor observed R5 slap CNS-B on the hand. CNS-B stated "stop, that is not okay." R5 verbalized to CNS-B she should not touch anything in his room. CNS-B verbalized to the surveyor it was very difficult to care for the residents at times due to the behaviors they dealt with. On November 13, 2024, at 7:45 a.m., ULP-C stated it could be really hard to handle the behaviors of the residents. ULP-C verbalized she updated the nurse when there were resident behavior concerns. ULP-C stated she had	0 630			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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
0 630	Continued From page 30 resident care experience but did not share the details of her experience to the surveyor. On November 13, 2024, at 8:45 a.m., CNS-B stated she was not aware a comprehensive nursing assessment was required, and was not aware of the assessment policy, or that the forms a nurse could utilize were located in the licensee's policy and procedure manual. CNS-B verbalized she planned to implement the policies and forms. On November 14, 2024, at 10:00 a.m., CNS-B stated she was not aware a current IAPP with the required content was not completed for R2, R3, or R4, and was not sure where the documentation would be located, but that she would make sure all the residents had a current IAPP which included all the required content with specific interventions. The surveyor showed CNS-B the licensee's policy and procedure manual including an IAPP policy and a blank form. The licensee's Individual Abuse Prevention Plan dated June 2021 indicated, "1. The plan will contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including: a. other vulnerable adults b. the person's risk of abusing other vulnerable adults, and c. statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. 2. For purposes of the abuse prevention plan, abuse includes self-abuse." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post the 911 emergency number in common areas and near telephones provided and to post the information and the reporting number for the Minnesota Adult Abuse Reporting Center (MAARC) to report suspected maltreatment of a vulnerable adult under section 626.557. 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) 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:	0 640			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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
0 640	Continued From page 32 On November 12, 2024, at 10:03 a.m., the surveyor observed the common areas shared by the residents, staff, and visitors with unlicensed personnel (ULP)-C. The licensee lacked the required posting of information for reporting suspected maltreatment to MAARC. In addition, the 911 emergency number was not posted in the common area of the facility or by the residents' shared telephone located on the counter, in the kitchen area. On November 12, 2024, at 11:35 a.m., licensed assisted living director/registered nurse (LALD/RN)-A stated the required postings were pulled down off the walls and the bulletin board by the residents. LALD/RN-A further stated this was why the MAARC number and 911 were no longer posted in the main area of the facility or by the shared telephone. On November 14, 2024, at 9:30 a.m., clinical nurse supervisor (CNS)-B stated she was not aware 911 was required to be posted in a common area or near a shared telephone. The licensee's 2.44 Vulnerable Adult Maltreatment - Prevention & Reporting policy dated June 2021, included 4. "[Licensee] will post information for reporting suspected crime and maltreatment. The facility will support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: a. Posting the 911 emergency number in common areas and near telephones provided by the assisted living facility. b. Posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult."	0 640			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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
0 640	Continued From page 33 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640			
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 observation, interview, and record review, the licensee failed to maintain a written emergency preparedness (EP) plan with all the	0 680			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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
0 680	Continued From page 34 required content as defined in the Center for Medicare and Medicaid Services (CMS)Appendix Z. The licensee further failed to post an emergency disaster plan, and emergency exit diagrams. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when 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: On November 12, 2024, at 10:03 a.m., during an observation of the entrance and main level of the facility with unlicensed personnel (ULP)-C, the facility lacked a posted EP plan and emergency exit diagrams. ULP-C stated she was not sure where the licensee kept the EP plan. The licensee's EP plan dated April 20, 2024, lacked the following: -post an emergency disaster plan prominently; -provide building emergency exit diagrams to all residents; -post emergency exit diagrams on each floor; -quarterly review of the missing resident policy; and -EP plan testing requirements including an annual full-scale exercise or individual facility-based functional exercise and a second full-scale exercise that was either community-based, an individual facility based functional exercise, a mock disaster drill, or a table-top exercise.	0 680			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431			
(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
0 680	Continued From page 35 On November 12, 2024, at 10:21 a.m., licensed assisted living director/registered nurse (LALD/RN)-A stated the emergency exit diagrams must have been pulled down by the residents. LALD/RN-A stated he believed this could be why the EP plan and emergency plan and exit diagrams were no longer posted in the main area of the facility. Also, LALD/RN-A verbalized he planned to get this posted. When requested, LALD/RN-A did not provide evidence of an annual full-scale exercise or individual facility-based functional exercise and a second full-scale exercise that was either community-based, an individual facility based functional exercise, a mock disaster drill, or a table-top exercise, during the survey. On November 14, 2024, at 9:20 a.m., LALD/RN-A stated he was not aware the EP manual was not developed to include all the required information. Also, LALD/RN-A verbalized the licensee did not have documented evidence the missing resident policy was reviewed quarterly. The licensee's 9.01 Emergency Preparedness Plan-Appendix Z Compliance Policy indicated the EP plan would include all the required elements of Appendix Z and would be based on the assisted living and community-based risk assessments, utilizing an all-hazards approach. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 700 SS=F	144G.43 Subdivision 1 Resident record	0 700			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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
0 700	Continued From page 36 (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure residents' personal health and medical information was kept private. This had the potential to affect four of four residents (R2, R3, R4, R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On November 12, 2024, at 10:30 a.m., licensed assisted living director/registered nurse (LALD/RN)-A and clinical nurse supervisor (CNS)-B stated, the resident records were stored in a kitchen cabinet near a computer station used by staff. On November 12, 2024, at 11:45 a.m., the surveyor observed the kitchen area where the resident records were stored, with CNS-B. The kitchen was a common shared area of the facility	0 700			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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
0 700	Continued From page 37 for staff and residents. The resident medical records were stored in an upper kitchen cabinet that was unlocked. CNS-B verbalized she was not aware the resident medical records were required to be secure and locked. The licensee's 2.36 Resident Records - Confidentiality policy dated June 2021, indicated "Resident records will be kept confidential and locked in a secure area where only authorized staff of [Licensee] have access to it." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 700			
0 780 SS=I	144G.45 Subd. 2 (a) (1) Fire protection and physical environment 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	0 780			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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
0 780	Continued From page 38 buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the smoking requirements under Minnesota State Fire Code, Minnesota Rules 7511. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On November 13, 2024, from approximately 10:06 a.m. to 12:00 p.m., the surveyor toured the facility with licensed assisted living director/registered nurse (LALD/RN)-A. During the tour, the surveyor observed evidence of improperly disposed of smoking materials with cigarette butts on the floor of resident sleeping rooms and burn marks present on floors and furniture. Cigarette butts were improperly disposed of onto rear deck and onto ground in front and rear yard. Occupied resident sleeping room 5: Extensive burns on floor from cigarettes improperly extinguished.	0 780	An immediate correction order was issued on November 13, 2024, for tag identification 0780. During the course of the survey, the licensee took action to mitigate the immediate risk. Noncompliance remained and the scope and level remain unchanged.		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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
0 780	Continued From page 39 Occupied resident sleeping room 2: Extensive burns on floor from cigarettes improperly extinguished. Resident smoked and dropped a cigarette on floor before stomping on it during time of inspection in the presence of LALD/RN-A and the surveyor. Unoccupied resident sleeping room 6: Dozens of discarded cigarette butts and several lighters on the floor, with burn marks on furniture and floor. Rear yard had multiple cigarette butts laying on the wooden porch and in surrounding plants. Approved smoking receptacle was not present during tour. LALD/RN-A retrieved a smoking receptacle from a vehicle and supplied it on rear porch during survey. Front entryway had many discarded cigarette butts laying on vegetation to the side of walkway. Surveyor explained to LALD/RN-A that smoking materials must be properly disposed of in approved noncombustible receptacles. On November 13, 2024, the surveyor explained to LALD/RN-A that an immediate correction order was issued for the above findings. LALD/RN-A stated they understood the requirements for disposal of smoking materials. TIME PERIOD FOR CORRECTION: Immediate Based on observation and interview, the licensee failed to comply with Minnesota State Fire Code. Per Minnesota State Fire Code locking on egress doors must not require special knowledge, equipment, or force, and must not impede egress.	0 780			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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
0 780	Continued From page 40 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On November 13, 2024, from approximately 10:06 a.m. to 12:00 p.m., the surveyor toured the facility with licensed assisted living director/registered nurse (LALD/RN)-A. During the tour the surveyor observed excessive locking mechanisms on the primary front door and the secondary front door to the facility. The primary front door had three locks installed including manual locking arrangements that required additional actions to open. The door had a snap closed locking apparatus installed at the top of the door frame and its operation was not easily interpreted, requiring special knowledge to open. The secondary front door had three locks installed including manual locking arrangements that required additional actions to open. The door had a chain locking mechanism installed at the top of the door frame requiring additional actions and effort to open. A wooden board was found to be kept on top of the stove in the kitchen with multiple burn marks. LALD/RN-A stated that the board is put on the stovetop after cooking. The storage of flammable materials on the stove may create a hazard for	0 780			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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
0 780	Continued From page 41 fire. Smoke alarms were present throughout the facility, however when the smoke alarms were tested by LALD/RN-A, there was not interconnection provided for most of the smoke alarms. When tested, the only alarms that sounded were in the upper hallway and in resident sleeping room 2. LALD/RN-A confirmed that no other alarms' interconnection was working. Evidence of hardwired mounting plate, wires and hardware indicate that hardwired smoke alarms were removed and replaced with wireless alarms. Hardwired alarms are required to be maintained and must be replaced with alarms of the same power supply. These deficient conditions were visually verified by LALD/RN-A accompanying on the tour and LALD/RN-A stated he understood the requirements. TIME PERIOD FOR CORRECTION: Two (2) days	0 780			
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program.	0 800			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 800	Continued From page 42 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On November 13, 2024, from approximately 10:06 a.m. to 12:00 p.m., the surveyor toured the facility with licensed assisted living director/registered nurse (LALD/RN)-A. During the tour, the surveyor observed the following: A light fixture near the front entry was broken, with the light hanging loose by its wires. Old smoke alarms past 10 years in age were present in the facility and should be removed. Resident sleeping room 6 contained significant dirt and filth. Room was unoccupied at time of inspection but contained sullied mattress and significant dirt, debris and cigarette butts on the floor. Resident sleeping room 6 had a lighting fixture	0 800			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 800	Continued From page 43 that was missing a globe and lightbulb, exposing the fixture. Basement bathroom vent cover was hanging loose and not properly attached to vent. Basement bathroom had peeling and chipping paint around shower. Laundry room fire extinguisher had current annual service tags, but did not have evidence of monthly facility inspections. Front entry fire extinguisher had current annual service tags, but did not have evidence of monthly facility inspections. Extinguisher was not properly maintained and had the safety pin removed from proper position. Laundry room dryer vent was not securely attached and there was significant buildup of dryer lint in surrounding area. Resident sleeping room 4 was missing outlet covers around electrical outlets. Front entryway had a picture hanging with broken glass. Front entry ramp had a broken baluster. Storage shed in rear yard has significantly rotted and degraded wood with pieces not securely attached, and missing pieces of glass in windows. During the facility tour interview on November 13, 2024, LALD/RN-A verified the above listed physical environment observations while accompanying on the tour.	0 800			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 800	Continued From page 44	0 800			
	TIME PERIOD FOR CORRECTION: Seven (7) days				
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) staff 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) Staff 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 staff 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.	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431			
(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
0 810	Continued From page 45 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop the fire safety and evacuation plan with required content, failed to provide the required training to employees and residents, and failed to conduct the required evacuation drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) 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: On November 13, 2024, at 12:00 p.m., licensed assisted living director/registered nurse (LALD/RN)-A provided documents on the fire safety and evacuation plan (FSEP) titled "Immediate Fire Procedure", fire safety and evacuation training, and evacuation drills for the facility. The licensee FSEP failed to include the following: The FSEP failed to identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. The FSEP failed to identify specific fire protection actions for employees. There was no section in the policy that addressed the responsibilities or	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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
0 810	Continued From page 46 basic evacuation procedures that employees should follow in case of a fire or similar emergency. Record review indicated the licensee failed to provide training to residents at least once per year LALD/RN-A was unable to provide documentation showing any training offered or training scheduled for a future date for residents on the fire safety and evacuation plan. Record review indicated the licensee failed to provide and document adequate training to employees on the FSEP upon hire and at least twice per year. LALD/RN-A failed to provide documentation of staff trainings on the fire safety and evacuation plan. Record review indicated that resident room number and locations were not provided and documented evacuation plans were inaccurate and did not match floor plan of facility. No evacuation maps were posted of the basement level in the facility nor were they provided in the FSEP. Resident sleeping rooms were not adequate labelled and numbered. During an interview on November 13, 2024, at 12:00 p.m., survey staff explained the requirements for frequency of drills, employee trainings and FSEP documents and LALD/RN-A stated they understood the requirements. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
0 830 SS=F	144G.45 Subd. 3 Local laws apply Assisted living facilities shall comply with all	0 830			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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
0 830	Continued From page 47 applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements, except a facility with a licensed resident capacity of six or fewer is exempt from rental licensing regulations imposed by any town, municipality, or county. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to follow applicable state and local laws, regulations, standards, ordinances, and codes related to smoking for two of four residents (R4, R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On November 12, 2024, at 10:03 a.m., the surveyor observed the main area of the facility including the bedrooms with unlicensed personnel (ULP)-C. There was a strong smell of cigarette smoke throughout the facility upon entry to the facility and throughout the facility. On November 12, 2024, at 10:10 a.m., the surveyor observed R4 and R5's bedrooms. The surveyor observed multiple, what appeared to be, old black burn marks in the floors of R4 and R5's	0 830			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431			
(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
0 830	Continued From page 48 bedrooms. In addition, R5 was observed lying in his bed which contained multiple empty plastic Boost bottles on the floor next to R5's bed. The Boost bottles appeared to have been used to place ashes. Also, ashes were visible around the floor next to R5's bed. There were stacks of paper and books strewn across the floor under the window. R5 stated "don't touch my stuff and don't throw anything away." R5 verbalized "yes" when asked if he smoked in his bedroom. The baseboards, floors, walls, doors and door handles appeared to have what appeared to be a black colored coating in many areas throughout the facility. On November 12, 2024, at 10:30 a.m., prior to the entrance conference, licensed assisted living director/registered nurse (LALD/RN)-A stated he was not able to keep the residents from smoking in the house and asked the surveyor what he should do. Both LALD/RN-A and clinical nurse supervisor (CNS)-B verbalized they had tried everything and had been unsuccessful getting R4 and R5 to smoke in the outside designated areas. On November 13, 2023, at 7:20 a.m., upon the surveyor's entry into the facility, on the second day of the survey, there continued to be a strong smell of cigarette smoke throughout the facility. On November 13, 2024, at 12:23 p.m., the surveyor observed R4 go into the garage with an unlit cigarette in his hand. LALD/RN-A went to garage and redirected R4 to the back outside deck to smoke. The back outdoor deck had several old cigarette butts lying on and round the deck area. LALD/RN-A stated there was not an appropriate smoking receptacle outside for disposal of the cigarettes because it had been thrown away by the residents. In addition,	0 830			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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
0 830	Continued From page 49 LALD/RN-A stated he did have a smoking receptacle in his car and would place it in the designated smoking area. On November 14, 2024, at 8:00 a.m., upon the surveyor's entry into the facility, on the third day of the survey, there continued to be a smell of cigarette smoke throughout the facility. On November 14, 2023, at 10:15 a.m., LALD/RN-A again stated he did not know how he would keep the residents from smoking in the facility and bedrooms. The Minnesota Department of Health's Minnesota Clean Indoor Air Act (MCIAA) amendment effective on August 1, 2019, noted smoking was prohibited in health care facilities and clinics. In addition, an indoor area meant a space between a floor and a ceiling that is at least half enclosed by walls, doorways, or windows (opened or closed) around the perimeter. A wall included retractable dividers, garage doors, plastic sheeting or any other temporary or permanent physical barrier. Minnesota State Statute 144.414 Prohibitions; Subdivision 3 dated 2022, indicated under a section titled Health care facilities and clinics: (a) Smoking is prohibited in any area of a hospital, health care clinic, doctor's office, licensed residential facility for children, or other health care-related facility, except that a patient or resident in a nursing home, boarding care facility, or licensed residential facility for adults may smoke in a designated separate, enclosed room maintained in accordance with applicable state and federal laws. No further information was provided.	0 830			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431			
(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
0 830	Continued From page 50	0 830			
0 900 SS=E	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced	0 900			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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
0 900	Continued From page 51 by: Based on interview and record review, the licensee failed to develop and execute a written contract with the required content for two of three residents (R3, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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: During the entrance conference on November 12, 2024, at 10:30 a.m., licensed assisted living director/registered nurse (LALD/RN)-A stated the licensee complied with the Minnesota (MN) assisted living laws and regulations. R3 R3 was admitted November 25, 2022, and had diagnoses including schizophrenia (a serious mental health disorder that affects how people think, feel, and behave), and major depressive disorder. R3's undated, and unsigned Service Plan indicated R3 received services including assistance with behavior management, toileting, and medication administration. R3's record lacked an assisted living (AL) contract signed by the licensee and R3 or R3's representative, outlining all the terms concerning the provision of housing and assisted living	0 900			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431			
(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
0 900	Continued From page 52 services. R4 R4 was admitted April 3, 2015, and had diagnoses including schizoaffective disorder (a chronic mental illness), cognitive impairment, and type two diabetes (insulin resistance). R4's Service Plan, dated November 11, 2018, indicated R4 received services including assistance with behavior management, bathing, laundry, and medication administration. R4's medical record lacked an AL contract signed by the licensee and R4 or R4's representative, outlining all the terms concerning the provision of housing and assisted living services. On November 13, 2024, at 12:45 p.m., LALD/RN-A stated he was not able to obtain a signature from R3 or R4 or their designated representative. LALD-A verbalized he had tried to reach out to the representatives but had been unable to get the contracts signed for R3 or R4. No further information was provided. TIME PERIOD TO CORRECT: Seven (7) days	0 900			
01440 SS=D	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	01440			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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
01440	Continued From page 53 and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a registered nurse (RN) conducted direct supervision of staff performing a delegated task within 30 days of providing services for one of one employee (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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-C started working June 2, 2023, and provided direct care services for residents of the	01440			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431			
(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
01440	Continued From page 54 facility. On November 13, 2024, at 7:35 a.m., through 8:22 a.m., the surveyor observed ULP-C administer medications to residents. ULP-C's employee record lacked evidence the RN conducted direct supervision of the employee performing a delegated task within 30 days after the employee had first performed the delegated task for residents. On November 14, 2024, at 9:30 a.m., clinical nurse supervisor (CNS)-B stated she was not sure why ULP-C's 30-day supervision was not in ULP-C's employee file. Also, CNS-B verbalized she must have missed completing the 30-day RN supervision for ULP-C. The licensee's 6.17 Supervision of Staff - Delegated Services dated June 1, 2021, included "1. Direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for [Licensee] and first performs the delegated tasks for residents and thereafter as needed based on performance." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440			
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's	01470			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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
01470	Continued From page 55 policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and	01470			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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
01470	Continued From page 56 the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employees received orientation to include all required content for one of two employees (clinical nurse supervisor (CNS)-B). 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: CNS-B was hired November 30, 2006, and began providing services under the Assisted Living license on August 1, 2021. On November 12, 2024, from 8:00 a.m. through	01470			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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
01470	Continued From page 57 9:00 a.m., the surveyor observed CNS-B assist ULP-C with direct care of the residents. CNS-B's employee record lacked documentation the following orientation to Assisted Living topics were completed: -an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; -handling of emergencies and use of emergency services; -the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; -handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; -consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and -a review of the types of assisted living services the employee will be providing and the facility's category of licensure. On November 14, 2024, at 9:30 a.m., CNS-B stated she was not able to find evidence she completed the above listed required orientation topics. The licensee's 5.01 Orientation of Staff and Supervisors & Content dated June 2021, included	01470			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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
01470	Continued From page 58 "All staff of [Licensee] providing and supervising direct services must complete an orientation to Assisted Living facility licensing requirements and regulations before providing assisted living services to residents." Also, indicated "3. The orientation must contain the following topics: -An overview of the appropriate Assisted Living statutes and rules; -An introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; -Handling of emergencies and use of emergency services; -Compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); -The assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; -Principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; -Handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; -Consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; -A review of the types of assisted living services the employee will be providing and the facility's category of licensure; -The staff person's job description upon hire and whenever there is a change to the job description	01470			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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
01470	Continued From page 59 that changes the nature of the job or how the job is to be performed; -The facility's organization chart and the roles of staff within the facility, and the services offered by the facility as identified in the uniform checklist disclosure of services; and -The identification of incidents of maltreatment as defined under Minnesota Statutes, section 626.5572, subdivision 15, including abuse, financial exploitation, and neglect, and an explanation that any act that constitutes maltreatment is prohibited. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470			
01530 SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource	01530			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431			
(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
01530	Continued From page 60 and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure all employees received the required initial eight hours of dementia care training and two hours annually for two of two employees (clinical nurse supervisor (CNS)-B, unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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). The findings include: On November 12, 2024, from 8:00 a.m. through 9:00 a.m., the surveyor observed CNS-B assist ULP-C with direct care of the residents. CNS-B CNS-B was hired November 30, 2006, and began providing cares under the Assisted Living license on August 1, 2021, assisting with the supervision of staff, and to provide direct cares and services	01530			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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
01530	Continued From page 61 to residents. CNS-B's employee record included 1.5 hours of initial dementia training, 6.5 hours less than the required 8 hours of dementia training for a supervisor of direct-care staff within 120 hours of start date and zero hours of annual dementia training. ULP-C ULP-C was hired June 2, 2023, to provide direct cares and services to licensee residents. ULP C's employee record included a document titled Assisted Living Training & Competencies manual dated April 30, 2023, which included a section labeled 3.05 (dementia training section). In the column required at orientation the document noted "no." documentation. In the column required annually the document indicated "yes." ULP-C's employee record lacked documentation of eight hours of dementia training within 160 hours of start date and two hours of annual dementia training. On November 14, 2024, at 10:00 a.m., licensed assisted living director/registered nurse (LALD/RN)-A and clinical nurse supervisor stated they were not able to find any further evidence of dementia care training for CNS-B and ULP-C. The licensee's 5.03 Dementia Training policy, dated June 2021, indicated "All staff of [Licensee] are required to complete dementia training at the time of hire and annually thereafter." Also, included "1. Supervisors of direct care staff will complete eight {8} hours of initial training within 120 hours of the employment start date. 2. Direct care employees will complete eight {8} hours of initial training within 160 hours of the employment	01530			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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
01530	Continued From page 62 start date. 3. Employees may not provide direct care until the training is complete unless another employee who has completed the initial training is present to provide assistance." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530			
01620 SS=F	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 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	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431			
(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
01620	Continued From page 63 by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident monitoring and reassessment, utilizing a uniform assessment tool, no more than 14 days after admission and not more than 90 days from the previous assessment for three of three residents (R2, R3, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On November 13, 2024, from 7:35 a.m. through 8:20 a.m., the surveyor observed ULP-C assist the licensee's residents with medication administration. R2 R2 was admitted May 4, 2018, and had diagnoses including bipolar affective disorder (a mental health disorder causing extreme mood shifts), major neurocognitive disorder (a decline in mental function), and polysubstance abuse (the use of more than one drug). R2's undated and unsigned Service Plan Agreement indicated R2 needed assistance with medication administration. R2's medical record included an initial assessment dated May 4, 2018, but lacked a 14	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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
01620	Continued From page 64 day assessment and subsequent 90 day comprehensive nursing assessments utilizing a uniform assessment tool. R3 R3 was admitted November 25, 2022, and had diagnoses including schizophrenia (a serious mental health disorder that affects how people think, feel, and behave), and major depressive disorder. R3's undated, and unsigned Service Plan indicated R3 needed assistance with behavior management, toileting, and medication administration. R3's medical record lacked an initial, 14 day and any subsequent 90 day comprehensive nursing assessments utilizing a uniform assessment tool. R4 R4 was admitted April 3, 2015, and had diagnoses including schizoaffective disorder (a chronic mental illness), cognitive impairment, and type two diabetes (insulin resistance). R4's Service Plan, dated November 11, 2018, indicated R4 needed assistance with behavior management, bathing, laundry, and medication administration. R4's medical record included an initial assessment dated November 25, 2014, but lacked a 14 day assessment and subsequent 90 day comprehensive nursing assessments utilizing a uniform assessment tool. On November 13, 2024, at 8:45 a.m., clinical nurse supervisor (CNS)-B stated she was not aware a comprehensive nursing assessment was	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431			
(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
01620	Continued From page 65 required. CNS-B stated she was not aware of the assessment policy, and the forms a nurse could utilize were located in the licensee's policy and procedure manual. Also, CNS-B verbalized she planned to implement the policies and forms with the residents. The licensee's 6.03 Uniform Assessment Tool policy dated June 2021, included "[Licensee] will use a uniform assessment tool that addresses all of the required elements." The licensee's 6.01 Assessments, Reviews, and Monitoring policy, dated June 2021, indicated "1. The initial nursing assessment or reassessment must include all the elements of the uniform assessment tool as required, conducted in person (unless see #2), be in writing, dated, and signed by the registered nurse who conducted the assessment. 2. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. 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 needs of the resident and cannot exceed 90 calendar days from the last date of the assessment." No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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
01640	Continued From page 66	01640			
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 by: Based on observation, interview, and record review, the licensee failed to ensure the current service plan included a signature or other authentication by the resident and the licensee to document agreement on the services to be provided for one of three residents (R3). Additionally, the licensee failed to ensure a written service plan was implemented no later than 14 days after the date services were first provided for one of three residents (R2).	01640			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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
01640	Continued From page 67 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: On November 13, 2024, from 7:35 a.m. through 8:20 a.m., the surveyor observed ULP-C assist R2 and R3 with medication administration. R2 R2 was admitted May 4, 2018, and had diagnoses including bipolar affective disorder (a mental health disorder causing extreme mood shifts), major neurocognitive disorder (a decline in mental function), and polysubstance abuse. R2's Service Plan Agreement dated May 4, 2018, and signed August 23, 2018 (111 days after start of services), indicated R2 received services including assistance with meals, housekeeping, bathing, grooming, and medication administration. R2's record lacked a signed written service plan within 14 days of R2's start of services. R3 R3 was admitted November 25, 2022, and had diagnoses including schizophrenia (a serious mental health disorder that affects how people think, feel, and behave) and major depressive disorder. R3's medical record included an unsigned Service Plan that indicated R3 received services	01640			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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
01640	Continued From page 68 including assistance with behavior management, toileting, and medication administration. R3's record lacked a signed written service plan within 14 days of R3's start of services. On November 13, 2024, at 12:00 p.m., licensed assisted living director/registered nurse (LALD/RN)-A stated R2 was unable to sign documents on his behalf and R2's representative was not able to sign the service agreement at the time of admission. In addition, LALD/RN-A verbalized he was not sure why there was no signatures by resident, resident's representative, or facility staff on R3's service plan. Finally, LALD/RN-A stated it is difficult to reach the residents representatives and get the documents completed. The licensee's 6.08 Service Plan policy dated June 2021, included "All residents receiving assisted living services will have a service plan in place. Service plans are based on the outcomes of initial and subsequent assessments, reassessments, monitoring, and individual reviews of the resident's needs and preferences." Also, indicated "2. The service plan and any revisions shall include a signature or other authentication by [Licensee] and by the resident, or resident's representative, documenting agreement on the services to be provided." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640			
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to	01650			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431			
(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
01650	Continued From page 69 (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan included the required content for three of three residents (R2, R3, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a	01650			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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
01650	Continued From page 70 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On November 13, 2024, from 7:35 a.m. through 8:20 a.m., the surveyor observed unlicensed personnel (ULP)-C assist R2, R3, and R4 with medication administration. R2 R2 was admitted May 4, 2018, and had diagnoses including bipolar affective disorder (a mental health disorder causing extreme mood shifts), major neurocognitive disorder (a decline in mental function), and polysubstance abuse. R2's undated and unsigned Service Plan Agreement indicated R2 received services including assistance with medication administration. R2's service plan lacked the following: -a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; -the identification of staff or categories of staff who will provide the services; -the schedule and methods of monitoring assessments of the resident; -the schedule and methods of monitoring staff providing services; -a contingency plan that includes: -the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has	01650			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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
01650	Continued From page 71 authority to sign for the resident in an emergency; and -the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. R3 R3 was admitted November 25, 2022, and had diagnoses including schizophrenia (a serious mental health disorder that affects how people think, feel, and behave) and major depressive disorder. R3's undated, and unsigned Service Plan indicated R3 received services including assistance with behavior management, toileting, and medication administration. R3's service plan lacked the following required content: -the identification of staff or categories of staff who will provide the services; and -the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency. R4 R4 was admitted April 3, 2015, and had diagnoses including schizoaffective disorder (a chronic mental illness), cognitive impairment, and type two diabetes (insulin resistance). R4's Service Plan dated November 11, 2018, indicated R4 received services including assistance with behavior management, bathing, laundry, and medication administration. R4's service plan lacked the following required content:	01650			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431			
(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
01650	Continued From page 72 -a contingency plan that includes: the action to be taken if the scheduled service cannot be provided; -the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and -the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. On November 13, 2024, at 10:50 a.m., licensed assisted living director/registered nurse (LALD/RN)-A stated he was not aware of the required content of the service plan. The surveyor educated LALD/RN-A and clinical nurse supervisor (CNS)-B on the policies and documents available to the licensee in their policy and procedure manual. The licensee's 6.08 Service Plan policy dated June 2021, included, 9. A service plan will include: a. A description of the services that are to be provided based on the most recent assessment and resident preferences; b. Fees for services to be provided; c. The frequency of each service to be provided based on the most recent assessment and resident preferences; d. An identification of staff or categories of staff who will be providing services (RN, LPN, unlicensed personnel, etc.); e. A schedule and method for the next planned assessment or monitoring; and f. A schedule and method for the next planned	01650			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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
01650	Continued From page 73 monitoring of staff providing services. g. A contingency plan that includes: i. Actions [Licensee] will take if scheduled services cannot be provided ii. Information regarding how the resident can contact [Licensee] iii. The names and contact information the resident wishes, if any, to have notified in an emergency or if there is a significant adverse change in the resident's condition iv. Identification and contact information of who the resident has authorized, if any, to sign for the resident in an emergency v. How the facility will support documented resident health care directive decisions, if any - including circumstances when emergency medical services are not to be summoned. Also, indicated "Other optional documents such as "care plans", "assignment sheets", or other internal documents may be used to assist staff in understanding their daily assignments and tasks, but such documents are not required and do not replace the required service plan." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650			
01710 SS=F	144G.71 Subd. 3 Individualized medication monitoring and reas The assisted living facility must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually.	01710			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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
01710	Continued From page 74 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted a face-to-face medication management reassessment at least annually for three of three residents (R2, R3, R4) who received medication management 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, 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). The findings include: On November 13, 2024, from 7:35 a.m. through 8:20 a.m., the surveyor observed unlicensed personnel (ULP)-C assist the licensee's residents with medication administration. R2 R2 was admitted May 4, 2018, and had diagnoses including bipolar affective disorder (a mental health disorder causing extreme mood shifts), major neurocognitive disorder (a decline in mental function), and polysubstance abuse (the use of more than one drug). R2's undated and unsigned Service Plan Agreement indicated R2 received services including assistance with medication administration. R3	01710			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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
01710	Continued From page 75 R3 was admitted November 25, 2022, and had diagnoses including schizophrenia (a serious mental health disorder that affects how people think, feel, and behave) and major depressive disorder. R3's undated, and unsigned Service Plan indicated R3 received services including assistance with behavior management, toileting, and medication administration. R4 R4 was admitted April 3, 2015, and had diagnoses including schizoaffective disorder (a chronic mental illness), cognitive impairment, and type two diabetes (insulin resistance). R4's Service Plan dated November 11, 2018, indicated R4 received services including assistance with behavior management, bathing, laundry, and medication administration. R2, R3, and R4's medical records lacked an initial and annual reassessment of the resident's medication management services as needed when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. On November 13, 2024, at 8:45 a.m., clinical nurse supervisor (CNS)-B stated she was not aware there was a requirement to complete a medication assessment for the residents who received medication administration assistance. The surveyor showed CNS-B and licensed assisted living director/registered nurse (LALD/RN)-A the licensee's policy on the medication management assessments. CNS-B verbalized she was not aware of this policy.	01710			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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
01710	Continued From page 76 The licensee's 7.01 Medication Management - Assessment, Monitoring & Reassessment policy dated June 2021, indicated "[Licensee] will, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber conduct an assessment to determine what medication management services will be provided and how the services will be provided. Also, included "1) The assessment must be conducted face-to-face with the resident by an RN. 2) The assessment must include an identification and review of all medications the resident is known to be taking. 3) The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. 4) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. ** "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. 5) [Licensee] will monitor and reassess the resident's medication management services as needed when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01710			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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
01730	Continued From page 77	01730			
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes.	01730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431			
(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
01730	Continued From page 78 (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an individualized medication management plan with the required content for three of three residents (R2, R3, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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). The findings include: On November 13, 2024, from 7:35 a.m. through 8:20 a.m., the surveyor observed unlicensed personnel (ULP)-C assist the licensee's residents with medication administration. R2 R2 was admitted May 4, 2018, and had diagnoses including bipolar affective disorder (a mental health disorder causing extreme mood shifts), major neurocognitive disorder (a decline in mental function), and polysubstance abuse (the use of more than one drug). R2's undated and unsigned Service Plan Agreement indicated R2 received services	01730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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
01730	Continued From page 79 including assistance with medication administration. R3 R3 was admitted November 25, 2022, and had diagnoses including schizophrenia (a serious mental health disorder that affects how people think, feel, and behave) and major depressive disorder. R3's undated, and unsigned Service Plan indicated R3 received services including assistance with behavior management, toileting, and medication administration. R4 R4 was admitted April 3, 2015, and had diagnoses including schizoaffective disorder (a chronic mental illness), cognitive impairment, and type two diabetes (insulin resistance). R4's Service Plan dated November 11, 2018, indicated R4 received services including assistance with behavior management, bathing, laundry, and medication administration. R2, R3, and R4's medical records lacked an individualized medication management plan with the following required content including: -a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; -documentation of specific resident instructions relating to the administration of medications; -identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; -identification of medication management tasks that may be delegated to unlicensed personnel;	01730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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
01730	Continued From page 80 -procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and -any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. On November 13, 2024, at 8:45 a.m., clinical nurse supervisor (CNS)-B stated she was not aware there was a requirement to complete a medication assessment and individualized medication management plan for the residents who received medication administration assistance. The surveyor showed CNS-B and licensed assisted living director/registered nurse (LALD/RN)-A the licensee's policy on the medication management plan. CNS-B verbalized she was not aware of this policy and a form available to use to complete the medication management plan was in the licensee's policy and procedure binder. The licensee's 7.03 Medication Management Individualized Plan policy dated June 2021, indicated "For each resident at [Licensee] medication management services, the facility will prepare and include in the service plan a written statement of the medication management services that will be provided to the resident." Also, included [Licensee] will develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: a. A statement describing the medication management services that will be provided;	01730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431			
(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
01730	Continued From page 81 b. A description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; c. Documentation of specific resident instructions relating to the administration of medications; d. Identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; e. Identification of medication management tasks that may be delegated to unlicensed personnel; f. Procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and g. Any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730			
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01760	Continued From page 82 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 accurately transcribed, and document the reason why medication administration was not completed as prescribed for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On November 13, 2024, at 7:35 a.m., the surveyor observed unlicensed personnel (ULP)-C assist R2 with medication administration. R2 was admitted May 4, 2018, and had diagnoses including bipolar affective disorder (a mental health disorder causing extreme mood shifts), major neurocognitive disorder (a decline in mental function), and polysubstance abuse (the use of more than one drug). R2's undated and unsigned Service Plan Agreement indicated R2 received services	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01760	Continued From page 83 including assistance with medication administration. R2's record included an unsigned After Visit Summary dated October 2, 2024, that indicated: -acetaminophen (for pain) 325 milligrams (mg), take 650 mg by mouth every four hours as needed; -atropine sulfate (for excess secretions) one percent (%) ophthalmic solution, place two drops under tongue, three times daily; -docusate sodium (a stool softener) 100 milligrams (mg), take one capsule, twice daily as needed; -diphenhydramine (an antihistamine) 50 mg, take one capsule, three times daily as needed; -haloperidol (for mental/mood disorders) 2 mg, with no instructions; -lithium carbonate (for manic episodes of bipolar disorder) 300 mg, take three capsules, at bedtime; -methimazole (to treat hyperthyroidism) 5 mg, take one half a tablet (2.5 mg) by mouth daily; -olanzapine (for mood disorders) 10 mg, take one tablet by mouth daily at bedtime; -olanzapine 5 mg, take one tablet by mouth two times daily; -propranolol (for high blood pressure)10 mg, take one tablet twice daily; -senna (a laxative) 8.6 mg, take three tablets, once daily; and -vitamin D3 (supplement) 50 micrograms (mcg), take one tablet daily. R2's medication administration record (MAR) for November 2024, indicated the following were administered November 1-12, 2024: -docusate sodium 100 mg, take one capsule, twice daily as needed; -senna 8.6 mg, take three tablets, once daily;	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01760	Continued From page 84 -haloperidol 10 mg, take one tablet twice daily; -lithium carbonate 300 mg, take three capsules, at bedtime; -diphenhydramine 50 mg, take one capsule, three times daily as needed; -haloperidol 2 mg, take one tablet at bedtime (with 10 mg tablet for a total dose of 12 mg); -atropine sulfate one (1) percent (%) ophthalmic solution, place two drops under tongue, three times daily; -olanzapine 5 mg, take one tablet, daily as needed; -propranolol 10 mg, take one tablet twice daily; -Robinul (decreases stomach acid) 1 mg, take one tablet every morning; -olanzapine 10 mg, take one tablet by mouth every morning; and -Gavilax (for constipation) powder 17 grams (Gm), in eight ounces (oz) of liquid, daily. R2's MAR did not indicate the following medications were administered as ordered on the After Visit Summary: -acetaminophen (for pain) 325 milligrams (mg), take 650 mg by mouth every four hours as needed; -vitamin D3 (supplement) 50 micrograms (mcg), take one tablet daily; and -methimazole (to treat hyperthyroidism) 5 mg, take one half a tablet (2.5 mg) by mouth daily. On November 13, 2024, at 9:45 a.m., licensed assisted living director/registered nurse (LALD/RN)-A and clinical nurse supervisor (CNS)-B stated they used the after-visit summaries from the resident's provider for the medication orders. CNS-B stated she must have made a transcription error on R2's MAR. The licensee's 7.16 Medication & Treatment	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01760	Continued From page 85 Orders - Implementing policy dated June 2021, 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	01760			
01820 SS=E	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 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 written or electronically recorded prescription for medications and obtained, and prescriptions were renewed at least every 12 months for two of three residents (R2, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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).	01820			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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
01820	Continued From page 86 The findings include: R2 R2 was admitted May 4, 2018, and had diagnoses including bipolar affective disorder (a mental health disorder causing extreme mood shifts), major neurocognitive disorder (a decline in mental function), and polysubstance abuse. R2's undated and unsigned Service Plan Agreement indicated R2 received services including assistance with medication administration. On November 13, 2024, at 7:50 a.m., the surveyor observed unlicensed personnel (ULP)-C assist R2 with medication administration. R2's medication administration record (MAR) for November 2024, indicated R2 was administered the following medications daily: -docusate sodium (a stool softener) 100 milligrams (mg), take one capsule, twice daily as needed; -senna (a laxative) 8.6 mg, take three tablets, once daily; -haloperidol (for mental/mood disorders) 10 mg, take one tablet twice daily; -lithium carbonate (for manic episodes of bipolar disorder) 300 mg, take three capsules, at bedtime; -diphenhydramine (an antihistamine) 50 mg, take one capsule, three times daily as needed; -haloperidol 2 mg, take one tablet at bedtime (with 10 mg tablet for a total dose of 12 mg); -atropine sulfate (for excess secretions) one percent (%) ophthalmic solution, place two drops under tongue, three times daily; -olanzapine (to treat mental disorders) 5 mg, take one tablet, daily as needed;	01820			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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
01820	Continued From page 87 -propranolol (for high blood pressure)10 mg, take one tablet twice daily; -Robinul (decreases stomach acid) 1 mg, take one tablet every morning; -olanzapine 10 mg, take one tablet by mouth every morning; and -Gavilax (for constipation) powder 17 grams (g), in eight ounces (oz) of liquid, daily. R2's medical record included an After Visit Summary dated August 16, 2023, and October 2, 2024. Both documents lacked a practitioner's handwritten signature. R2's record lacked signed orders for the above-listed medications. R4 R4 was admitted April 3, 2015, and had diagnoses including schizoaffective disorder (a chronic mental illness), cognitive impairment, and type two diabetes (insulin resistance). R4's Service Plan dated November 11, 2018, indicated R4 received services including assistance with behavior management, bathing, laundry, and medication administration. On November 13, 2024, at 8:07 a.m., the surveyor observed ULP-C assist R4 with blood glucose testing. R4's MAR for November 2024, indicated R4 was administered the following medications daily: -acetaminophen (for pain) 325 mg, take two tablets, every six hours, as needed; -mirtazapine (for depression) 15 mg, take one tablet daily at bedtime; -lurasidone hydrochloride (for mental health disorders) 120 mg, take one tablet daily, with evening meal; -melatonin (for insomnia) 3 mg, take one tablet	01820			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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
01820	Continued From page 88 daily at bedtime; -hydroxyzine (an antihistamine) 50 mg, take one tablet three times daily; -Banophen (an antihistamine) 25 mg, take two capsules daily at bedtime; -Vraylar (an antipsychotic) 4.5 mg, take one capsule daily; -lisinopril (for high blood pressure) 40 mg, take one tablet daily; -Metformin (to control blood glucose) 500 mg extended release (ER), take two tablets twice daily; -Basaglar (long-acting insulin) pen 100 units/ml, inject 24 units subcutaneously daily; -senna 8.6 mg, take one tablet twice daily as needed; -glipizide (decrease blood sugar) 5 mg, take one tablet daily; -aspirin (for pain) 82 mg, chewable, one tablet daily; -Norvasc (for high blood pressure) 10 mg, take one tablet daily; -Admelog (fast-acting insulin) 100u/ml, inject six units subcutaneously three times daily with meals plus sliding scale for blood glucose levels greater than 150; and -Depakote (for mental health and mood disorders) extended release (ER) 500 mg, take five tablets daily at bedtime. R4's medical record included an After Visit Summary dated October 5, 2021. The After Visit Summary included a medication list, but lacked a practitioner's handwritten signature. R4's record lacked signed orders for the above-listed medications. On November 13, 2024, at 12:00 p.m., clinical nurse supervisor (CNS)-B stated she used the medication list from R2's after-visit summary	01820			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431			
(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
01820	Continued From page 89 dated August 16, 2023. CNS-B verbalized she was not aware of the requirement of renewal of prescriptions every 12 months. Also, CNS-B stated she was not aware the After Visit Summary for R2 and R4 did not contain a signed prescription order from the provider. In addition, CNS-B was unable to locate or provide the provider orders for R4. On November 14, 2024, at 9:15 a.m., CNS-B acknowledged signed orders needed to be updated every 12 months and stated she would implement this process. Minnesota Statutes section 151.01 Definitions Subd. 16a Prescription indicated, "A prescription written or printed on paper that is given to the patient or an agent of the patient or that is transmitted by fax must contain the practitioner's manual signature. An electronic prescription must contain the practitioner's electronic signature." The licensee's 7.18 Medication and Treatment Orders-Renewal policy, dated June 2021, indicated medication orders would be sent to the provider for signature at least every 12 months, and kept in the resident's record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820			
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer	01910			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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
01910	Continued From page 90 part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide documentation in the resident's record regarding the disposition of medication to include quantity and names of staff and other individuals involved in the disposition of medications for one of one discharged 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 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 discharged from the facility May 4, 2023.	01910			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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
01910	Continued From page 91 R1's Client Care plan and Assessment dated June 12, 2015, indicated R1 required assistance with medication administration. R1's record included a nursing progress note dated May 2, 2023, that indicated R1 notified the house manager he would be moving out in two days. R1's discharge nurses progress note, dated May 4, 2023, at 4:30 p.m., indicated, "The nurse came and hand (sic) over all resident medications to the resident with instruction on how to take his medications". No further progress notes were entered. R1's record lacked documentation of medication disposition upon discharge, to include -medication name; -strength; -prescription number as applicable; -quantity; and -names of staff and other individuals involved in the disposition. On November 14, 2024, at 9:25 a.m., licensed assisted living director/registered nurse (LALD/RN)-A stated R1 decided to leave the facility on a short notice, they gave the medications to R1, and they did not document his medication disposition upon discharge. The Licensee's 7.23 Medication Disposal policy dated June 2021, indicated "Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of	01910			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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
01910	Continued From page 92 staff and other individuals involved in the disposition." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910			
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 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	01940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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 93 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 two residents (R4) receiving treatment 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R4 had diagnoses including schizoaffective disorder (a chronic mental illness), cognitive impairment, and type two diabetes (insulin resistance). On November 13, 2024, at 8:07 a.m., the surveyor observed unlicensed personnel (ULP)-C assist R4 with blood glucose testing. On November 13, 2024, at 8:30 a.m., clinical nurse supervisor (CNS)-B stated the licensee completed R4's blood glucose testing three times daily with meals. R4's Service Plan, dated November 11, 2018, indicated R4 received services including assistance with behavior management, bathing, laundry, and medication administration. The	01940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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 94 service plan lacked any indication the licensee would assist R4 with blood glucose monitoring. On November 13, 2024, at 8:30 a.m., CNS-B stated the licensee completed R4's blood glucose testing three times daily with meals. R4's Care Plan Diabetes Management document dated November 29, 2014, indicated R4 required monitoring of blood glucose per provider order. R4's record lacked a treatment management plan related to R4's blood glucose testing including: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (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. On November 13, 2024, at 8:40 a.m., clinical nurse supervisor (CNS)-B stated she was not aware there was a requirement to complete an individualized treatment management plan for the residents who received treatment administration assistance. The surveyor showed CNS-B and licensed assisted living director/registered nurse (LALD/RN)-A the licensee's policy on the treatment management plan. CNS-B verbalized	01940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431			
(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 95 she was not aware of this policy or that the form available to use to complete the treatment management plan was in the licensee's policy and procedure binder. The licensee's 7.05 Treatment & Therapy Management Plan policy dated June 2021, included 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 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; and g. Monitoring of treatment or therapy to prevent possible complications or adverse reactions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940			
01950 SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or	01950			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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
01950	Continued From page 96 other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure training and competency was completed for blood glucose testing for one of one employee (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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-C began working June 2, 2023, and provided direct care services to residents.	01950			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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
01950	Continued From page 97 On November 13, 2024, at 8:07 a.m., the surveyor observed ULP-C assist R4 with blood glucose testing. On November 13, 2024, at 8:30 a.m., clinical nurse supervisor (CNS)-B stated the licensee completed R4's blood glucose testing three times daily with meals. ULP-C's employee record lacked documentation of training and competency testing in performing blood glucose checks for R4. On November 13, 2024, at 9:00 a.m., CNS-B stated she thought ULP-C was trained on performing blood sugar testing but could not say the date of the training. On November 14, 2024, at 9:10 a.m., CNS-B stated she was not able to find documented evidence of ULP-C's blood glucose training and competency evaluation. The licensee's 6.14 Delegation of Assisted Living Services policy, dated June 2021, included "1. When the registered nurse or licensed health professional at [Licensee] delegates tasks to unlicensed personnel, that person will ensure that prior to the delegation the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each resident and is able to demonstrate the ability to competently follow the procedures and perform the tasks. 2. If an unlicensed personnel has not regularly performed the delegated assisted living task for a period of 24 consecutive months, the unlicensed personnel will demonstrate competency in the task to the registered nurse or appropriate licensed health professional. 3. The registered nurse or licensed	01950			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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
01950	Continued From page 98 health professional will document instructions for the delegated tasks in the resident's record. 4. A RN may delegate nursing services to a person who has successfully completed staff orientation, who has been trained in the service to be provided, and who has demonstrated to the RN the ability to competently follow the procedures for the resident." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950			
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to obtain prescriber orders for all treatments and therapies, including the frequency, duration and other information needed to administer the treatment or therapy for one of two residents (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	01970			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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
01970	Continued From page 99 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: R4 had diagnoses including schizoaffective disorder (a chronic mental illness), cognitive impairment, and type two diabetes (insulin resistance). R4's Service Plan, dated November 11, 2018, indicated R4 received services including assistance with behavior management, bathing, laundry, and medication administration. On November 13, 2024, at 8:07 a.m., the surveyor observed unlicensed personnel (ULP)-C assist R4 with blood glucose testing. ULP-C verbalized they completed R4's blood glucose testing three times daily. On November 13, 2024, at 8:30 a.m., clinical nurse supervisor (CNS)-B stated the licensee completed R4's blood glucose testing three times daily with meals. R4's medication administration record (MAR) for November 2024, included blood sugar readings documented three times daily November 1-12, 2024, with values ranging from 105-292 milligrams per deciliter. R4's medical record lacked a prescriber order for R4's blood glucose testing. On November 13, 2024, at 9:20 a.m., CNS-B stated she would look to see if there was an order	01970			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431			
(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
01970	Continued From page 100 for R4's blood glucose testing. On November 14, 2024, at 9:10 a.m., CNS-B stated she was not able to find evidence of a blood glucose testing order for R4. The licensee's 7.20 Medication & Treatment Orders policy dated June 2021, indicated, "To ensure a current, written prescriber's order must be obtained for any treatment or medication administration provided to a resident. Prescriptions or orders that are to be implemented must be received from an authorized prescriber. And, to ensure ongoing evaluation of medications and treatments." Also. included "1) The RN is responsible for assuring that: a. current, authorized prescriber orders for medications or treatments administered by the staff are kept on file in the residents' records; b. communicated to the resident or responsible party; c. educate resident or responsible party on all medication and treatment orders, and d. changes in orders are addressed in the resident's service plan and are communicated to the other staff. 2) An order for medication or treatment must contain the name of the resident, a description of the medication, treatment, or therapy to be provided and the frequency, duration, and other information needed to carry out the order. 3) An order for medication or treatment must be dated, signed by the prescriber and must be current and consistent with the resident's nursing assessment." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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
02240 SS=F	144G.90 Subdivision 1 Assisted living bill of rights; notification (a) An assisted living facility must provide the resident a written notice of the rights under section 144G.91 before the initiation of services to that resident. The facility shall make all reasonable efforts to provide notice of the rights to the resident in a language the resident can understand. (b) In addition to the text of the assisted living bill of rights in section 144G.91, the notice shall also contain the following statement describing how to file a complaint or report suspected abuse: "If you want to report suspected abuse, neglect, or financial exploitation, you may contact the Minnesota Adult Abuse Reporting Center (MAARC). If you have a complaint about the facility or person providing your services, you may contact the Office of Health Facility Complaints, Minnesota Department of Health. If you would like to request advocacy services, you may contact the Office of Ombudsman for Long-Term Care or the Office of Ombudsman for Mental Health and Developmental Disabilities." (c) The statement must include contact information for the Minnesota Adult Abuse Reporting Center and the telephone number, website address, email address, mailing address, and street address of the Office of Health Facility Complaints at the Minnesota Department of Health, the Office of Ombudsman for Long-Term Care, and the Office of Ombudsman for Mental Health and Developmental Disabilities. The statement must include the facility's name, address, email, telephone number, and name or title of the person at the facility to whom problems or complaints may be directed. It must also include a statement that the facility will not retaliate because of a complaint.	02240			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431			
(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
02240	Continued From page 102 (d) A facility must obtain written acknowledgment from the resident of the resident's receipt of the assisted living bill of rights or shall document why an acknowledgment cannot be obtained. Acknowledgment of receipt shall be retained in the resident's record. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the current Minnesota Bill of Rights for Assisted Living Residents was provided to the resident for three of three residents (R2, R3, R4). This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), and 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: The licensee had a current assisted living license effective March 1, 2024. On November 13, 2024, from 7:35 a.m. through 8:20 a.m., the surveyor observed unlicensed personnel (ULP)-C assist residents with medication administration. R2 R2 was admitted May 4, 2018, and had diagnoses including bipolar affective disorder (a mental health disorder causing extreme mood shifts), major neurocognitive disorder (a decline	02240			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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
02240	Continued From page 103 in mental function), and polysubstance abuse (the use of more than one drug). R2's undated and unsigned Service Plan Agreement indicated R2 received services including assistance with medication administration. R2's Service Plan Agreement dated May 4, 2018, included a copy of the Home Care Bill of Rights but lacked a signed acknowledgement of receiving the current Assisted Living Bill of Rights. R3 R3 was admitted November 25, 2022, and had diagnoses including schizophrenia (a serious mental health disorder that affects how people think, feel, and behave) and major depressive disorder. R3's undated, and unsigned Service Plan indicated R3 received services including assistance with behavior management, toileting, and medication administration. R4 R4 was admitted April 3, 2015, and had diagnoses including schizoaffective disorder (a chronic mental illness), cognitive impairment, and type two diabetes (insulin resistance). R4's Service Plan dated November 11, 2018, indicated R4 received services including assistance with behavior management, bathing, laundry, and medication administration. R3 and R4's medical record lacked a signed acknowledgement of receiving the current Assisted Living Bill of Rights, or documentation of why the acknowledgement could not be signed.	02240			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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
02240	Continued From page 104 On November 13, 2024, at 12:45 p.m., licensed assisted living director (LALD/RN)-A stated he was not able to obtain a signature that acknowledged the assisted living bill of right was provided to R3, R4, or their designated representative. In addition, LALD/RN-A stated he was not aware R2's service plan agreement only acknowledged receipt of the home care bill of rights. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02240			
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards including assessment and documentation of education of risk versus benefit of side rails for two of four residents (R2, R3). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to	02310	An immediate correction order was issued November 12, 2024, for tag identification 2310. The licensee failed to submit a complete plan of correction; the scope and severity remain at level 3, widespread.		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
02310	Continued From page 105 serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2 had diagnoses which included bipolar affective disorder, and major neurological cognitive disorder. R3 had diagnoses which included paranoid schizophrenia. On November 12, 2024, at 10:03 a.m., the surveyor observed the resident bedrooms with unlicensed personnel (ULP)-C. Upon entry into R3's bedroom (number 3), the surveyor observed a hospital style bed with bilateral upper half side rails, left side rail in the downward position and the right side rail in the upright position. Next, ULP-C and the surveyor observed R2's bedroom (number 2) had a hospital style bed with bilateral upper half side rails, both in the upright position. ULP-C stated R2 and R3 resided in bedrooms 2 and 3. R2 and R3's medical records both lacked: -an assessment for appropriate and safe use of side rail as an assistive device; -documentation of correct installation including measurements of Food and Drug Administration (FDA) identified zones of entrapment; and -documentation of education and discussion of the risks and benefits of side rails with the resident or residents responsible party. On November 12, 2024, at 11:04 a.m., clinical nurse supervisor (CNS)-B stated R2 and R3 did	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
02310	Continued From page 106 not use the side rails, so an assessment was not required. CNS-B and licensed assisted living director/registered nurse (LALD/RN)-A verbalized they had not completed an assessment including measurements to ensure the side rails were FDA compliant. CNS-B and LALD/RN-A further stated they had not discussed risk versus benefits with the residents. On November 12, 2024, at 12:35 p.m., the surveyor shared the Minnesota Department of Health (MDH) Assisted Living: Resources and Frequently Asked Questions (FAQ) website with the licensee via email. The FDA guidance, A Guide to Bed Safety, revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." On page 21, Table 3 Summary of FDA Hospital Bed Dimensional Limit Recommendations indicated specific measurement limits for each entrapment zone. The licensee's Side Rail Use policy dated June 2021, indicated: "When [Licensee] is aware a home care resident is utilizing side rails (a medical device) on a bed, [Licensee] will assess the use, educate the resident, and when appropriate, the responsible person, regarding the risks and benefits of side rails, and verify that	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
02310	Continued From page 107 the side rail in use is of a safe design and utilized consistent with the manufacturer's directions. This policy shall be followed regardless of who owns or is supplying the side rail." The MDH Assisted Living: Resources and FAQ's website accessed on November 12, 2024, at 12:30 p.m., read under Hospital-style bed rails, that licensees should ensure, "measurements were completed and documented, the rails were FDA compliant, and the risk versus benefits were discussed and documented with the resident/responsible party." No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	02310			
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the required posting at the main entry way of the facility, included statutory language to disclose electronic monitoring activity, potentially affecting all current residents in the assisted living facility, staff, and any visitors to the facility.	03090			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER THE JAMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431		
(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
03090	Continued From page 108 This practice resulted in a level one violation (a violation that has not potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On November 12, 2024, at 10:03 a.m., upon entrance to the facility, the surveyor observed the licensee lacked an electronic monitoring notice with the required statutory language. On November 12, 2024, at 11:35 a.m., licensed assisted living director/registered nurse (LALD/RN)-A stated the electronic monitoring posting was pulled down off the wall by the residents. Also, LALD/RN-A verbalized he could repost the electronic monitoring posting, but it would likely be pulled down again by the residents. The licensee's 2.15 Electronic Monitoring policy dated June 2021, indicated "1. Signs are installed at each facility entrance accessible to visitors that state: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons or activities." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090			

Type: Full
Date: 11/13/24
Time: 10:53:21
Report: 8044241357

Food and Beverage Establishment Inspection Report

Page 1

Location:

The James Inc
10549 Beard Avenue South
Bloomington, MN55431
Hennepin County, 27

Establishment Info:

ID #: 0039368
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9522043158
ID #:

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

The following orders were issued during this inspection.

2-200 Employee Health

2-201.11C

**** Priority 1 ****

MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority at the specific request of the regulatory authority.

No illness log.

Log provided.

Comply By: 11/13/24

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

3-302.11A(1)

**** Priority 1 ****

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

Head of lettuce stored in same bin as raw pork in refrigerator.

Comply By: 11/13/24

3-500B Microbial Control: hot and cold holding

3-501.16A2

**** Priority 1 ****

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

Milk and raw pork in refrigerator measured above 41 degrees F.

Ensure that groceries stay below 41 degrees F during transport from grocery store to facility.

Type: Full
Date: 11/13/24
Time: 10:53:21
Report: 8044241357
The James Inc

Food and Beverage Establishment Inspection Report

Page 2

Comply By: 11/13/24

4-500 Equipment Maintenance and Operation

4-501.114A **** Priority 1 ****

MN Rule 4626.0805A Use the approved sanitizer according to the rule and the EPA approved manufacturer's label.

Lysol spray used to sanitize counters.

Use a spray bottle of chlorine sanitizer instead.

Comply By: 11/13/24

4-600 Cleaning Equipment and Utensils

4-602.11A **** Priority 1 ****

MN Rule 4626.0845A Clean and sanitize food-contact surfaces of equipment and utensils: 1. before each use with a different type of raw animal food; 2. each time there is a change from working with raw foods to working with ready-to-eat foods; 3. between uses with raw fruits and vegetables and TCS foods; 4. before using or storing a food temperature measuring device; 5. at any time during the operation when contamination may have occurred.

Soiled probe for stem thermometer.

Probe cleaned while on site.

Comply By: 11/13/24

4-700 Sanitizing Equipment and Utensils

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

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

Dishwasher does not sanitize surface of dishes to 160 degrees F.

Obtain a dishwasher with a sanitize cycle that will heat the surface of the dishes to 160 degrees F.

Dishes currently sanitized in tub of chlorine sanitizer on counter.

Comply By: 11/13/24

4-300 Equipment Numbers and Capacities

4-302.14 **** Priority 2 ****

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

No chlorine test kit.

Comply By: 11/13/24

Type: Full
Date: 11/13/24
Time: 10:53:21
Report: 8044241357
The James Inc

Food and Beverage Establishment Inspection Report

6-300 Physical Facility Numbers and Capacities

6-301.12 ** Priority 2 **

MN Rule 4626.1445 Provide and maintain a supply of individual disposable towels, a continuous towel system, a heated-air hand drying device, or an approved ambient air temperature hand drying device at each handwashing sink or group of adjacent handwashing sinks.

No paper towels at handwashing sink.

Towels provided upon request.

Comply By: 11/13/24

6-300 Physical Facility Numbers and Capacities

6-301.14A

MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands

Sign not posted in kitchen or restroom.

Comply By: 11/13/24

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.12A

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

Soiled floors beneath refrigerator and stove.

Soiled backsplash behind stove.

Comply By: 11/19/24

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 49.0 Degrees Fahrenheit - Location: Milk in fridge
Violation Issued: Yes

Process/Item: Cold Holding
Temperature: 53.1 Degrees Fahrenheit - Location: Raw pork in fridge
Violation Issued: Yes

Process/Item: Cold Holding
Temperature: 40.0 Degrees Fahrenheit - Location: Fridge
Violation Issued: No

Total Orders	In This Report	Priority 1	Priority 2	Priority 3
		6	2	2

HRD inspection conducted with nurse evaluator Dede Hinnendael. Inspection report reviewed on site with James.

Type: Full
Date: 11/13/24
Time: 10:53:21
Report: 8044241357
The James Inc

Food and Beverage Establishment Inspection Report

Page 4

Domestic kitchen consists of tile floors and walls, painted gypsum ceiling, wooden hollow base cabinets, granite counters, and domestic equipment. Dishwasher not in use.

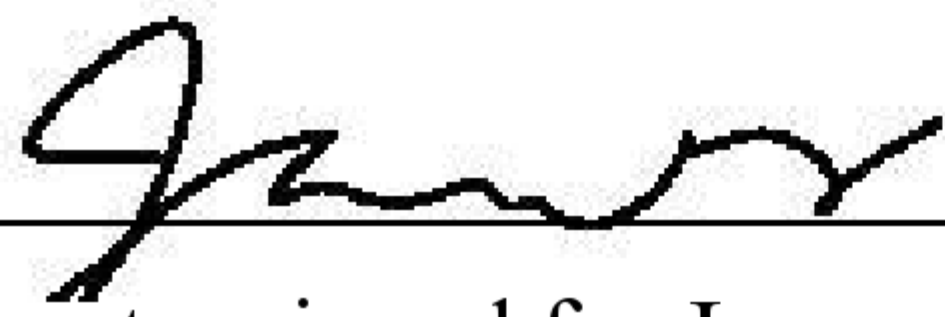
NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 8044241357 of 11/13/24.

Certified Food Protection Manager James Imasuen

Certification Number: FM112312 Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed: 
Inspector signed for James

Signed: 
Michael DeMars, RS
Public Health Sanitarian III
Rochester District Office
507-216-1096
michael.demars@state.mn.us

Report #: 8044241357

DEPARTMENT OF HEALTH

Minnesota Department of Health

Division of Environmental Health, FPLS

P.O. Box 64975

St. Paul, MN 55164-0975

No. of RF/PHI Categories Out

5

No. of Repeat RF/PHI Categories Out

0

Legal Authority MN Rules Chapter 4626

Date

11/13/24

Time In

10:53:21

Time Out

The James Inc

Address

10549 Beard Avenue South

City/State

Bloomington, MN

Zip Code

55431

Telephone

9522043158

License/Permit #

0039368

Permit Holder

Purpose of Inspection

Full

Est Type

Risk Category

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item

Mark "X" in appropriate box for COS and/or R

IN=in compliance OUT= not in compliance N/O= not observed N/A= not applicable COS=corrected on-site during inspection R= repeat violation

Compliance Status

COS

R

Supervision

1

IN

OUT

PIC knowledgeable; duties & oversight

2

IN

OUT

N/A

Certified food protection manager, duties

Employee Health

3

IN

OUT

Mgmt/Staff;knowledge,responsibilities&reporting

4

IN

OUT

Proper use of reporting, restriction & exclusion

5

IN

OUT

Procedures for responding to vomiting & diarrheal events

Good Hygienic Practices

6

IN

OUT

N/O

Proper eating, tasting, drinking, or tobacco use

7

IN

OUT

N/O

No discharge from eyes, nose, & mouth

Preventing Contamination by Hands

8

IN

OUT

N/O

Hands clean & properly washed

9

IN

OUT

N/A

N/O

No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed

10

IN

OUT

Adequate handwashing sinks supplied/accessible

Approved Source

11

IN

OUT

Food obtained from approved source

12

IN

OUT

N/A

N/O

Food received at proper temperature

13

IN

OUT

Food in good condition, safe, & unadulterated

14

IN

OUT

N/A

N/O

Required records available; shellstock tags, parasite destruction

Protection from Contamination

15

IN

OUT

N/A

N/O

Food separated and protected

16

IN

OUT

N/A

Food contact surfaces: cleaned & sanitized

17

IN

OUT

Proper disposition of returned, previously served, reconditioned, & unsafe food

Compliance Status

COS

R

Time/Temperature Control for Safety

18

IN

OUT

N/A

N/O

Proper cooking time & temperature

19

IN

OUT

N/A

N/O

Proper reheating procedures for hot holding

20

IN

OUT

N/A

N/O

Proper cooling time & temperature

21

IN

OUT

N/A

N/O

Proper hot holding temperatures

22

IN

OUT

N/A

Proper cold holding temperatures

23

IN

OUT

N/A

N/O

Proper date marking & disposition

24

IN

OUT

N/A

N/O

Time as a public health control: procedures & records

Consumer Advisory

25

IN

OUT

N/A

Consumer advisory provided for raw/undercooked food

Highly Susceptible Populations

26

IN

OUT

N/A

Pasteurized foods used; prohibited foods not offered

Food and Color Additives and Toxic Substances

27

IN

OUT

N/A

Food additives: approved & properly used

28

IN

OUT

Toxic substances properly identified, stored, & used

Conformance with Approved Procedures

29

IN

OUT

N/A

Compliance with variance/specialized process/HACCP

Risk factors (RF) are improper practices or proceeedures identified as the most prevalent contributing factors of foodborne illness or injury. Public Health Interventions (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is not in compliance Mark "X" in appropriate box for COS and/or R COS=corrected on-site during inspection R= repeat violation

COS

R

Safe Food and Water

30

IN

OUT

N/A

Pasteurized eggs used where required

31

Water & ice obtained from an approved source

32

IN

OUT

N/A

Variance obtained for specialized processing methods

Food Temperature Control

33

Proper cooling methods used; adequate equipment for temperature control

34

IN

OUT

N/A

N/O

Plant food properly cooked for hot holding

35

IN

OUT

N/A

N/O

Approved thawing methods used

36

Thermometers provided & accurate

Food Identification

37

Food properly labled; original container

Prevention of Food Contamination

38

Insects, rodents, & animals not present

39

Contamination prevented during food prep, storage & display

40

Personal cleanliness

41

Wiping cloths: properly used & stored

42

Washing fruits & vegetables

COS

R

Proper Use of Utensils

43

In-use utensils: properly stored

44

Utensils, equipment & linens: properly stored, dried, & handled

45

Single-use/single service articles: properly stored & used

46

Gloves used properly

Utensil Equipment and Vending

47

Food & non-food contact surfaces cleanable, properly designed, constructed, & used

48

X

Warewashing facilities: installed, maintained, & used; test strips

49

Non-food contact surfaces clean

Physical Facilities

50

Hot & cold water available; adequate pressure

51

Plumbing installed; proper backflow devices

52

Sewage & waste water properly disposed

53

Toilet facilities: properly constructed, supplied, & cleaned

54

Garbage & refuse properly disposed; facilities maintained

55

X

Physical facilities installed, maintained, & clean

56

Adequate ventilation & lighting; designated areas used

57

Compliance with MCIAA

58

Compliance with licensing & plan review

Food Recalls:

Person in Charge (Signature)

Inspector (Signature)

Date: 11/13/24