DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

June 2, 2023

Licensee
Harmony House Of Brainerd
218 9th Street Southwest
Brainerd, MN 56401

RE: Project Number(s) SL20415015

Dear Licensee:

On May 31, 2023, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the April 20, 2023, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Jodi Johnson, Supervisor
State Evaluation Team
Email: jodi.johnson@state.mn.us
Telephone: 651-344-2730 Fax: 651-281-9796

PMB

Electronically Delivered

May 1, 2023

Licensee
Harmony House Of Brainerd
218 9th Street Southwest
Brainerd, MN 56401

RE: Project Number(s) SL20415015

Dear Licensee:

On April 20, 2023, 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 January 19, 2023. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the January 19, 2023 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey completed on January 19, 2023, found not corrected at the time of the April 20, 2023, follow-up survey and/or subject to penalty assessment are as follows:

2310-Appropriate Care And Services-144g.91 Subd. 4 (a) = $3,000.00

The details of the violations noted at the time of this follow-up survey completed on April 20, 2023 (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 $3,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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.

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.

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 the MDH within 15 calendar days of the correction order receipt date.

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

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 MDH 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. Requests for hearing may be emailed to: **Health.HRD.Appeals@state.mn.us**.

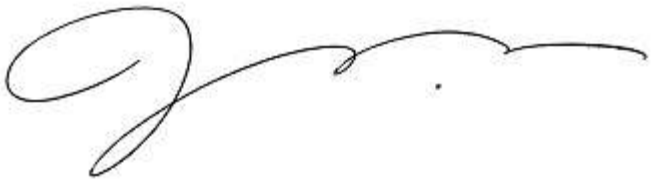
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both.

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: 651-281-9796

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20415	A. BUILDING: _____ B. WING _____	R 04/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOUSE OF BRAINERD I	218 9TH STREET SW BRAINERD, MN 56401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: Project SL20415015-1 On April 19, through April 20, 2023, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on January 17, 2023. At the time of the survey, there were 15 residents: 15 receiving services under the Assisted Living with Dementia Care license. As a result of the revisit, the following orders were reissued and/or issued. An immediate correction order was identified on April 20, 2023, reissued for SL20415015-1, tag identification 2070.	{0 000}		
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents:	{0 480}		

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{0 480}	Continued From page 1 (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: No further action required	{0 480}		
{0 550} SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: No further action required	{0 550}		
{0 720} SS=F	144G.43 Subd. 2 Access to records The facility must ensure that the appropriate records are readily available to employees and contractors authorized to access the records. Resident records must be maintained in a	{0 720}		

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{0 720}	Continued From page 2 manner that allows for timely access, printing, or transmission of the records. The records must be made readily available to the commissioner upon request. This MN Requirement is not met as evidenced by: No further action required	{0 720}		
{0 900} SS=F	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.	{0 900}		

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{0 900}	Continued From page 3 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 by: No further action required	{0 900}		
{01060} SS=D	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to:	{01060}		

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{01060}	Continued From page 4 (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: No further action required	{01060}		
{01650} SS=D	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an	{01650}		

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{01650}	Continued From page 5 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: No further action required	{01650}		
{01890} SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: No further action required	{01890}		
{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	{01940}		

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{01940}	Continued From page 6 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 be current and updated when there are any changes. This MN Requirement is not met as evidenced by: No further action required	{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 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	{01950}		

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{01950}	Continued From page 7 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: No further action required	{01950}		
{02070} SS=I	144G.81 Subd. 4 Awake staff requirement An assisted living facility with dementia care providing services in a secured dementia care unit must have an awake person who is physically present in the secured dementia care unit 24 hours per day, seven days per week, who is responsible for responding to the requests of residents for assistance with health and safety needs, and who meets the requirements of section 144G.41, subdivision 1, clause (12). This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one or more persons were physically present and available 24 hours a day, seven days a week, who were responsible for responding to requests for assistance with health and safety needs of residents in two of two secured memory care units. This had the potential to affect all 15 residents residing in the memory care unit.	{02070}		

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{02070}	Continued From page 8	{02070}		

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:

The licensee held an Assisted Living with Dementia Care license with a bed capacity of 20 residents and had a current census of 15 residents.

The physical layout of the facility included a secured memory care (MC) unit located on the north side of the building and a second secured MC unit located on the south side of the building. Each MC unit required key coded access from a large central area near the main entry door.

On April 19, 2023, at 12:10 p.m., during the entrance conference, licensed assisted living director in residency (LALDR)-A confirmed the licensee's staffing schedule included three unlicensed personnel (ULP) scheduled on the overnight shift (10:00 p.m. to 6:00 a.m.), one ULP for the south MC unit, one ULP for the north MC unit, and one ULP sleeper to float between north and south MC units as needed. LALDR-A indicated there were residents in the north and south MC units who required assistance of two staff to transfer via a Hoyer lift and for repositioning throughout the night.

The licensee's staffing plan undated, indicated

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{02070}	Continued From page 9 three staff were scheduled for each night shift. The licensee's staffing schedule and timecard data from April 9, through April 22, 2023, indicated two ULPs worked the overnight shift on April 12, 2023, and two ULPs worked from 4:00 a.m. through 6:00 a.m. on April 14, 2023. On April 20, 2023, at 9:16 a.m., registered nurse (RN)-C stated LALDR-A takes care of the employee schedule and coverage of overnight shifts. On April 20, 2023, at 9:58 a.m., LALDR-A stated for April 12, 2023, a staff member called in for the overnight shift and with the staffing crisis in Minnesota, the licensee did not have a replacement for a third staff member. LALDR-A stated for April 14, 2023, the sleeper ULP was awoken to work 4:00 a.m. through 6:00 a.m., as the temporary agency staff left at 4:00 a.m., leaving two staff members and no replacement for a third staff member. The licensee's Staffing and Scheduling policy dated August 1, 2021, indicated the clinical nurse supervisor would develop and implement a written staffing plan that provides an adequate number of qualified direct-care staff to meet the residents needs 24-hours a day, seven-days a week. Additionally, the policy indicated the clinical nurse supervisor would ensure that staff levels were adequate to address licensees secured memory care units. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	{02070}		

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{02310}	Continued From page 10	{02310}		
{02310} SS=D	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: No further action required	{02310}		
{02410} SS=D	144G.91 Subd. 13 Personal and treatment privacy (a) Residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a resident's space by knocking on the door and seeking consent before entering, except in an emergency or unless otherwise documented in the resident's service plan. (b) Residents have the right to have and use a lockable door to the resident's unit. The facility shall provide locks on the resident's unit. Only a staff member with a specific need to enter the unit shall have keys. This right may be restricted in certain circumstances if necessary for a resident's health and safety and documented in the resident's service plan. (c) Residents have the right to respect and privacy regarding the resident's service plan. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or	{02410}		

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{02410}	Continued From page 11 assistance. This MN Requirement is not met as evidenced by: No further action required	{02410}		

Electronically Delivered

February 10, 2023

Licensee
Harmony House Of Brainerd I
218 9th Street Southwest
Brainerd, MN 56401

RE: Project Number(s) SL20415015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on January 19, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment.

The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5)(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

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

St - 0 - 2070 - 144g.81 Subd. 4 - Awake Staff Requirement - $3,000.00

The total amount you are assessed is $3,000.00. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction for approval.

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the Department of Health within 15 calendar days of the correction order receipt date.

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

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

Free from Maltreatment reconsideration requests should be addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

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. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

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.

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

Sincerely,

Casey DeVries, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: casey.devries@state.mn.us
Phone: 651-201-5917 Fax: 651-215-6894

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20415	A. BUILDING: _____ B. WING _____	01/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOUSE OF BRAINERD I	218 9TH STREET SW BRAINERD, MN 56401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL20415015-0 On January 17, 2023, through January 19, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 14 residents, all of whom received services under the provider's Assisted Living with Dementia license. An immediate correction order was identified on January 18, 2023, issued for SL20415015-0, tag identification 2070. On January 19, 2023, the immediacy of correction order 2070 was removed, however, non-compliance remained at a level 3, scope of widespread violation.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 included document titled, Food and Beverage Establishment Inspection Report dated January 17, 2023, for the specific	0 480		

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0 480	Continued From page 2 Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post the required information related to reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC). This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	0 550		

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0 550	Continued From page 3 The findings include: On January 17, 2023, during the facility tour at approximately 9:30 a.m., the evaluator observed facility common areas with administrative assistant (AA)-B and noted the lack of required posting for information related to reporting suspected maltreatment to MAARC. On January 19, 2023, at approximately 1:00 p.m., licensed assisted living director in residency (LALDR)-A confirmed the content noted above was not posted as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 720 SS=F	144G.43 Subd. 2 Access to records The facility must ensure that the appropriate records are readily available to employees and contractors authorized to access the records. Resident records must be maintained in a manner that allows for timely access, printing, or transmission of the records. The records must be made readily available to the commissioner upon request. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to ensure resident records were maintained and Minnesota Department of Health (MDH) evaluator had access to the requested records. The licensee was unable to produce the requested facility records for three of three	0 720		

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0 720	Continued From page 4 resident's (R1, R2, R6). 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 January 17, 2023, at approximately 1:00 p.m., the evaluator requested contract records for R1, R2, and R6. Licensed assisted living director in residency (LALDR)-A stated the contracts had been provided to the residents and signed prior to his employment, however, some of the documents were missing. LALDR-A provided a partial contract (the first and second page) for R1, the first four pages of a contract titled with a different licensee name for R2 and the first two pages of a contract for R6. On January 18, 2023, at 3:34 p.m., LALDR-A stated the partial documents he had provided to the evaluator was what he could find. Additionally, LALDR-A stated, "with all the changes, a regional came here and told us we didn't need all this stuff and boxed up a bunch of stuff. I have no idea which boxes those might be stored in. I don't have them". No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) Days	0 720		

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0 780	Continued From page 5	0 780		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so 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 provisions of the Minnesota State Fire Code and failed to provide smoke alarms in all sleeping rooms. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 780		

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0 780	Continued From page 6 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On a facility tour on January 18, 2023, at approximately 11:15 a.m. with maintenance technician (M)-J and director in residence (LALDR)-A, it was observed that smoke detectors and not alarms, were installed in all resident rooms throughout the facility and did not provide audible or visual alarm notification within the resident room. On the tour M-J and LALDR-A verbally verified these deficient findings at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) 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. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment,	0 800		

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0 800	Continued From page 7 including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation regarding the health, safety, comfort, and well-being of the residents. This deficient condition had the potential to affect all staff, residents, 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). Findings include: On a facility tour on January 18, 2023, at approximately 11:15 a.m. with maintenance technician (M)-J and director in residence (LALDR)-A, the marked exit doors were observed with a keyed lock to control use of the door in the direction of egress travel leading from the common living room into the exit vestibule which leads to the courtyard in both the north and south house. These marked exit doors are required to be available for immediate use for exiting at all times as designed. On the same facility tour, storage items were observed obstructing the means of egress in the exit vestibule leading from the kitchen to the courtyard in both the north and south house. Keeping this required means of egress clear of obstructions helps provide access to the exits for occupants during an emergency. Missing electrical outlet covers were observed	0 800		

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0 800	Continued From page 8 behind the refrigerator in the food storage room in the basement, on the wall to the right and next to the fire sprinkler riser and in the furnace room in the new addition of the basement. The outlet covers prevent contact to exposed wire connections by objects or occupants of the building. A ground wire cheater plug was observed on the refrigerator in the food storage room in the basement. Electrical appliances are required to be used and maintained according to the manufactures listing. A fuel gas valve was observed with an open-ended pipe on the down stream side of the valve in the food storage room in the basement. This open-ended pipe with no cap or plug would dispense natural gas into the facility in the event of accidental opening of the valve. These deficient conditions were visually verified by M-J and LALDR-A accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and	0 810		

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0 810	Continued From page 9 (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on a record review and interview, the licensee failed to develop a fire safety and evacuation plan with required elements, failed to provide required employee and resident training on fire safety and evacuation, and failed to conduct the required evacuation drills. This had the potential to affect all staff, residents, 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	0 810		

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0 810	Continued From page 10 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). A record review and interview were conducted on January 18, 2023, at approximately 10:15 a.m. of documents provided by maintenance technician (M)-J and director in residence (LALDR)-A on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Findings include: Record review of the available documentation indicated that the licensee did not maintain the fire safety and evacuation plan for the facility as follows: Record review of the available documentation indicated that the fire safety and evacuation plan did not include specific fire protection procedures for employees in the event of a fire or similar emergency. Record review of the available documentation indicated that the fire safety and evacuation plan did not include fire protection procedures for residents in the event of a fire or similar emergency. Record review of the available documentation indicated that the fire safety and evacuation plan did not include procedures for employees regarding resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation.	0 810		

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0 810	Continued From page 11 Record review of the available documentation indicated that employees did not receive training on the facility fire safety and evacuation plan upon initial hire and twice per year thereafter. Record review of the available documentation indicated that the licensee did not provide training at least once per year to residents who are capable of self-evacuation on the proper actions to be taken in the event of a fire regarding movement, evacuation, and relocation. Record review of the available documentation did not indicate that evacuation drills had been conducted twice per year per shift and at least once every other month as required. All deficiencies were verified by M-J and LALDR-A during the interview at approximately 10:15 a.m. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 900 SS=F	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.	0 900		

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0 900	Continued From page 12 (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 by: Based on interview and record review, the licensee failed to develop and execute a written contract, with the required content for two of two unlicensed personnel (ULP)-K, ULP-L) residing in the lower level 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 the potential to	0 900		

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0 900	Continued From page 13 affect a large portion or all of the residents). The findings include: On January 17, 2023, at approximately 11:15 a.m., the evaluator reviewed a staff roster with licensed assisted living director in residency (LALDR)-A. The evaluator asked if licensee employed any temporary and/or contract staff. LALDR-A stated licensee did employ temporary and contract staff and two of the long-term temporary staff resided in the lower unit of the facility. ULP-K ULP-K was hired on May 18, 2018, under the comprehensive license and continued to provide direct care for licensee's residents after August 1, 2021, under the assisted living license. ULP-L ULP-L was hired on May 15, 2020, under the comprehensive license and continued to provide direct care for licensee's residents after August 1, 2021, under the assisted living license. On January 17, 2023, at approximately 2:30 p.m., the evaluator was provided and reviewed a document titled PowerScheduler Printout dated December 18, 2022, through January 28, 2023, which indicated ULP-K and ULP-L were scheduled shifts within the facility weekly. LALDR-A stated ULP-K and ULP-L had resided in a room in the lower level of the facility since being hired and "provide a lot of floor coverage". Additionally, LALDR-A stated he was unaware of the regulation that an assisted living may not provide housing to any individual unless it has executed a contract.	0 900		

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0 900	Continued From page 14 No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 900		
01060 SS=D	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case	01060		

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01060	Continued From page 15 manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation to the resident, the resident's legal representative, or designated representative. Further, the licensee failed to notify the Office of Ombudsman for Long-Term Care of a resident relocation following four days of absence from the facility for one of one discharged resident (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 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 was admitted to licensee on June 20, 2014. R4's progress notes dated December 15, 2022, through January 17, 2023, indicated R4 was transferred to the hospital on December 28, 2022, after staff reported resident was unable to keep any food down "again today".	01060		

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01060	Continued From page 16 R4's record lacked documentation R4's designated representative received an emergency relocation notice with all required content. Additionally, R4's record lacked documentation the licensee notified the Office of Ombudsman for Long-Term Care of R4's relocation following four days of absence from the facility. On January 18, 2023, at 8:57 a.m., licensed assisted living director in residency (LALDR)-A and registered nurse (RN)-C stated neither were aware of the requirement of notification to the Office of Ombudsman for Long-Term Care of a resident relocation following four days of absence from the facility. RN-C stated licensee would notify the required individuals in the future. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01650 SS=D	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes:	01650		

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01650	Continued From page 17 (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 all required content for one of three residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 admitted for assisted living services on January 4, 2022. R1's diagnosis included pseudomonal sepsis and	01650		

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01650	Continued From page 18 chronic diastolic heart failure. R1's Service Plan Agreement dated January 4, 2022, indicated R1 received services to include medication administration, bed mobility, bathing/showering assist, catheter care, dressing, grooming, housekeeping and laundry. On January 18, 2023, at 8:30 a.m., the evaluator observed unlicensed personnel (ULP)-E apply a tubigrip (an elastic compression bandage to aid venous and lymphatic return in the management of venous disorders of the legs and arms) to R1's left leg. R1's physician orders, dated January 4, 2023, indicated R1 required assistance with support stockings twice daily. R1's Service Plan dated January 4, 2022, lacked the following required content: - a description of the services to be provided, and the frequency of each service, according to the resident's current assessment and resident preferences; and - the identification of staff or categories of staff who will provide the services. On January 19, 2023, at approximately 9:30 a.m., registered nurse (RN)-C verified R1's service plan did not include a description of the services to be provided, and the frequency of each service, according to the resident's current assessment and resident preferences or the identification of staff or categories of staff who would provide the services. The licensee's Service Plan policy dated August 1, 2021, indicated the service plan must include a description of the services that are to be provided	01650		

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01650	Continued From page 19 based on the most recent assessment and resident preferences, the frequency of each service and an identification of staff or categories of personnel who would provide the service. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, licensee failed to date time-sensitive medications with an opened-on date 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, 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:	01890		

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01890	Continued From page 20 On January 17, 2023, at 9:37 a.m., while on tour of the facility administrative assistant (AA)-B stated licensee provided medication management services for residents who received services. On January 17, 2023, at approximately 9:50 a.m., the evaluator reviewed medications in the locked medication cart located on the south memory care unit with unlicensed personnel (ULP)-E. R2's Albuterol HFA 90 microgram (mcg) inhaler lacked labels to indicate the date staff removed the inhalers from the pouch and when the inhaler would expire. The manufacturer's instructions for the use of the Albuterol HFA inhaler dated 2019 directed for the inhaler to be discarded twelve months after it had been opened from the foil tray. The directions also indicated the tray opened and discard dates should be written on the inhaler label. On January 19, 2023, at approximately 8:20 a.m., registered nurse (RN)-C confirmed all time sensitive medications including the above noted time sensitive medications should be dated after opening with an open date and expiration date. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
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	01940		

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01940	Continued From page 21 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 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 an individual treatment management plan to include all required content for one of three residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	01940		

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01940	Continued From page 22 cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on January 17, 2023, at approximately 10:20 a.m., licensed assisted living director in residency (LALDR)-A confirmed the licensee provided treatment and therapy services to residents. R1 admitted for assisted living services on January 4, 2022. R1's diagnosis included pseudomonal sepsis and chronic diastolic heart failure. R1's Service Plan Agreement dated January 4, 2022, indicated R1 received services to include medication administration, bed mobility, bathing/showering assist, catheter care, dressing, grooming, housekeeping and laundry. On January 18, 2023, at 8:30 a.m., the evaluator observed unlicensed personnel (ULP)-E apply a tubigrip (an elastic compression bandage to aid venous and lymphatic return in the management of venous disorders of the legs and arms) to R1's left leg. R1's physician orders, dated January 4, 2023, indicated R1 required assistance with support stockings twice daily. R1's 90-day reassessment dated December 16, 2022, lacked inclusion of the tubigrip treatment.	01940		

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01940	Continued From page 23 R1's Service Plan dated January 4, 2022, lacked the inclusion of tubigrips. R1's Individualized Treatment and Therapy Plan dated January 17, 2023, did not include tubigrip treatments. R1's record lacked an Individualized Treatment and Therapy plan to include the following: - a statement of the type of services that will be provided; - documentation of specific resident instructions relating to the treatment or therapy administration; - procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and - any resident-specific requirements related to documentation of treatment and therapy was received, verification all treatment and therapy was administered as prescribed, and monitoring occurred to prevent possible complications or adverse reactions. On January 19, 2023, at approximately 10:00 a.m., registered nurse (RN)-C confirmed R1's Individualized Treatment and Therapy Plans lacked the above noted requirements. 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	01950		

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01950	Continued From page 24 must be administered by a nurse, physician, or 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 (3) communicated with the unlicensed personnel about the individual needs of the resident. 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) specified, in writing, specific instructions and documented those instructions in the resident record for one of three residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).	01950		

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01950	Continued From page 25 The findings include: R1 admitted for assisted living services on January 4, 2022. R1's diagnosis included pseudomonal sepsis and chronic diastolic heart failure. R1's Service Plan Agreement dated January 4, 2022, indicated R1 received services to include medication administration, bed mobility, bathing/showering assist, catheter care, dressing, grooming, housekeeping and laundry. R1's service plan lacked inclusion of the tubigrip treatment. On January 18, 2023, at 8:30 a.m., the evaluator observed unlicensed personnel (ULP)-E apply a tubigrip (an elastic compression bandage to aid venous and lymphatic return in the management of venous disorders of the legs and arms) to R1's left leg. On January 19, 2022, at approximately 9:40 a.m., RN-C acknowledged ULPs were applying and removing a tubigrip for R1, however, there were no specific instructions provided to staff regarding the daily monitoring and use of the tubigrips. RN-C confirmed R1 lacked a treatment record indicating what the treatment needs were of the resident and any specific instructions that would instruct staff how to complete and document the tubigrip treatment. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20415	A. BUILDING: _____ B. WING _____	01/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOUSE OF BRAINERD I	218 9TH STREET SW BRAINERD, MN 56401

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02070	Continued From page 26	02070		
02070 SS=I	144G.81 Subd. 4 Awake staff requirement An assisted living facility with dementia care providing services in a secured dementia care unit must have an awake person who is physically present in the secured dementia care unit 24 hours per day, seven days per week, who is responsible for responding to the requests of residents for assistance with health and safety needs, and who meets the requirements of section 144G.41, subdivision 1, clause (12). This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one or more persons were physically present and available 24 hours a day, seven days a week, who were responsible for responding to requests for assistance with health and safety needs of residents in two of two secured memory care units. This had the potential to affect all 14 residents residing in the memory care unit. 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: The licensee held an Assisted Living with Dementia Care license with a bed capacity of 20 residents and had a current census of 14 residents.	02070	On January 19, 2023, the immediacy of correction order 2070 was removed, however, non-compliance remained at a level 3, scope of widespread violation.	

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02070	Continued From page 27 The physical layout of the facility included a secured memory care (MC) unit located on the north side of the building and a second secured MC unit located on the south side of the building. Each MC unit required key coded access from a large central area near the main entry door. On January 17, 2023, at 10:20 a.m., during the entrance conference, licensed assisted living director in residency (LALDR)-A confirmed the facility's staffing schedule included two unlicensed personnel (ULP) scheduled on the overnight shift (6:00 p.m. to 6:00 a.m.), one ULP for the south MC unit and one ULP for the north MC unit. On January 18, 2023, at 7:15 a.m., the evaluator observed ULP-F and ULP-H transfer R6 from a hospital bed to a Broda chair (specialized wheelchair) with the use of a Hoyer lift (mechanical lift operated by a hydraulic system). ULP-F and ULP-H confirmed there were two staff scheduled for the overnight shift, one staff for the south MC unit, and one staff for the north MC unit. ULP-H stated the licensee had previously employed a "sleeper" staff member to float between north and south MC units as needed, however, "that was a long time ago". ULP-H stated there were three residents in the north MC unit and two residents in the south MC unit who required assistance of two staff to transfer via a Hoyer lift and for repositioning throughout the night. ULP-H stated the two staff assisted each other in the units to answer call lights and with two-person transfers/repositioning, leaving one MC unit unattended of staff while doing so. On January 18, 2023, at 7:45 a.m., RN-C stated, "I've shared concerns about that (two staff on	02070		

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	20415	A. BUILDING: _____ B. WING _____	01/19/2023

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02070	Continued From page 28	02070		

nights) repeatedly with the director [LALDR]." LALDR-A stated the facility is staffed based on case mix (resident level of need and census) and according to case mix information, the facility required two staff to be scheduled on the night shift. Additionally, LALDR-A and RN-C stated they were unaware of the requirement to ensure one or more persons were physically present and available 24 hours a day, seven days a week, who were responsible for responding to requests for assistance with health and safety needs of residents. LALDR-A and RN-C confirmed both were employed with the licensee for less than six months, and the facility has been staffed with two ULPs at night since prior to LALDR-A and RN-C being hired.

On January 18, 2023, at 8:25 a.m., LALDR-A provided the evaluator with the licensee's staffing plan and confirmed two staff were scheduled for each night shift, one ULP for the north MC unit and one ULP for the south MC unit.

On January 18, 2023, at 8:47 a.m., the evaluator reviewed the staffing schedule from December 1, 2022, to January 18, 2023, which indicated two ULP's were scheduled for the overnight shifts. Registered nurse (RN)-C confirmed as far back as August 2022, the licensee scheduled two staff to work the night shift, one staff for each MC unit.

The licensee's Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) dated May 12, 2021, indicated two unlicensed direct care staff awake and one sleeper would be scheduled on the night shift.

On January 18, 2023, at 8:57 a.m., the evaluator reviewed incidents reported during the period of July 1, 2022, through January 18, 2023. The

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02070	Continued From page 29 Incident Summary Report indicated seven of 13 falls occurred between the hours of 10:00 p.m. and 6:00 a.m., at which time only two staff were present in the building. The licensee's Staffing and Scheduling policy dated August 1, 2021, indicated the clinical nurse supervisor would develop and implement a written staffing plan that provides an adequate number of qualified direct-care staff to meet the residents needs 24-hours a day, seven -days a week. Additionally, the policy indicated the clinical nurse supervisor would ensure that staff levels were adequate to address licensees secured memory care units. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE On January 19, 2023, the immediacy of correction order 2070 was removed, however, non-compliance remained at a level 3, scope of widespread violation.	02070		
02310 SS=D	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	02310		

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02310	Continued From page 30	02310		

standards, medical or nursing standards for one of three residents (R6) who utilized alarms.

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:

R6's record lacked evidence the registered nurse (RN) completed an assessment/reassessment prior to the placement and use of a bed alarm.

On January 18, 2023, at 7:20 a.m., the evaluator observed unlicensed personnel (ULP)-H and ULP-F transfer R6 from her bed to a Broda chair (ergonomically designed chair for individuals requiring long term care) with the use of a Hoyer (a mechanical lift). R6's bed was noted to have a bed pad alarm connected and active.

On January 18, 2023, at approximately 8:00 a.m., the evaluator asked ULP-H how often the bed alarm is activated. ULP-H stated bed alarms are active 24/7 and sends an alert message to staff pagers when a resident moves around or attempts to exit the bed by themselves.

R6's assessment dated November 4, 2022, did not address bed alarm use by R6.

On January 19, 2023, at approximately 1:00 p.m., RN-C verified that R6 had in place a Smart cordless bed sensor alarm and a current safety

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	20415	A. BUILDING: _____ B. WING _____	01/19/2023

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02310	Continued From page 31 assessment was not updated to reflect R6's individual needs for use of an alarm. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02310		
02410 SS=D	144G.91 Subd. 13 Personal and treatment privacy (a) Residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a resident's space by knocking on the door and seeking consent before entering, except in an emergency or where clearly inadvisable or unless otherwise documented in the resident's service plan. (b) Residents have the right to have and use a lockable door to the resident's unit. The facility shall provide locks on the resident's unit. Only a staff member with a specific need to enter the unit shall have keys. This right may be restricted in certain circumstances if necessary for a resident's health and safety and documented in the resident's service plan. (c) Residents have the right to respect and privacy regarding the resident's service plan. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. This MN Requirement is not met as evidenced by:	02410		

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02410	Continued From page 32 Based on observation and interview, the licensee failed to ensure privacy was maintained during medication administration for one of three residents (R6). 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 January 18, 2023, at 7:20 a.m., the evaluator observed unlicensed personnel (ULP)-F setup and administer a nebulizer treatment to R6, while R6 was sitting at a dining room table. Two co-residents were present at a table next to R6 and ULP-H was assisting with serving breakfast to all three residents. On January 18, 2023, at 7:27 a.m., the evaluator asked ULP-F and ULP-H if it was routine practice to administer nebulizer treatments in the dining room with co-residents present. ULP-F stated, "yeah, I always do them out here in the morning, then I can be watching other things". ULP-H stated, "it's about 50/50 of the time, depends what is going on". On January 19, 2023, at 8:57 a.m., registered nurse (RN)-C stated she did not believe that is what ULPs were taught by the previous nurse and nebulizer treatments should not be done in a central area with co-residents present.	02410		

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02410	Continued From page 33 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02410		

Minnesota Department of Health
Food, Pools & Lodging Services
P.O. BOX 64975
ST. PAUL, MN 55164-0975
651-201-4500

Type: Full
Date: *01/17/23*
Time: 11:30:00
Report: 1017231013

Food and Beverage Establishment Inspection Report

Location:
Harmony House
218-224 9th Street S.W.
Brainerd, MN56401
Crow Wing County, 18

Establishment Info:
ID #: 0015052
Risk: Medium
Announced Inspection: No

License Categories:

Expires on: / /

Operator:
Horizon Health, Inc.

Phone #: 2188284142
ID #: 16945

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 previously issued on 04/11/19 have NOT been corrected.

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

SAME 5.11.21. SERVE SAFE HAS BEEN COMPLETED. SUBMIT CREDENTIAL WITH ATTACHED APPLICATION. SAME 1.17.23.

Issued on: 04/11/19 *Comply By: 06/11/19*

The following orders were issued during this inspection.

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.

BOTH DISH MACHINES - NORTH AND SOUTH KITCHEN MEASURED LESS THAN 150 DEGREES F. SERVICE DISH MACHINE SO THAT UTENSIL TEMPERATURE MEETS 160 DEGREES F MINIMUM TEMPERATURE.

Comply By: 01/17/23

Surface and Equipment Sanitizers

Hot Water: = at 149 Degrees Fahrenheit
Location: DISH MACHINE NORTH
Violation Issued: Yes

Hot Water: = at 149 Degrees Fahrenheit
Location: DISH MACHINE SOUTH
Violation Issued: Yes

Type: Full
Date: *01/17/23*
Time: 11:30:00
Report: 1017231013
Harmony House

Food and Beverage Establishment Inspection Report

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 33 Degrees Fahrenheit - Location: BROCCOLI SOUP LOCATED IN UPRIGHT COOLER SOUTH
Violation Issued: No

Process/Item: Cold Holding
Temperature: 33 Degrees Fahrenheit - Location: HAMBURGER HELPER LOCATED IN UPRIGHT COOLER NORTH
Violation Issued: No

Process/Item: Cold Holding
Temperature: 41 Degrees Fahrenheit - Location: HAMBURGER LOCATED IN COOLER BASEMENT NORTH
Violation Issued: No

Process/Item: Cold Holding
Temperature: 41 Degrees Fahrenheit - Location: SOUR CREAM LOCATED IN COOLER BASEMENT NORTH
Violation Issued: No

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

DISCUSSION:

AVOID BARE HAND CONTACT WITH READY TO EAT FOOD, EMPLOYEE ILLNESS LOG, HAND WASHING.

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 1017231013 of 01/17/23.

Certified Food Protection Manager: TOM SANDBERG

Certification Number: _____ Expires: 01/13/23

Inspection report reviewed with person in charge and emailed.

Signed: _____
Establishment Representative

Signed: 

NATE TOPP
PUBLIC HEALTH SANITARIAN
ST. CLOUD
320.223.7333
NATE.TOPP@STATE.MN.US

Report #: 1017231013

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Food, Pools & Lodging Services
P.O. BOX 64975
ST. PAUL, MN 55164-0975

No. of RF/PHI Categories Out	2	**Date**	01/17/23
No. of Repeat RF/PHI Categories Out	1	**Time In**	11:30:00
Legal Authority MN Rules Chapter 4626		**Time Out**	

Harmony House	**Address** 218-224 9th Street S.W.	**City/State** Brainerd, MN	**Zip Code** 56401	**Telephone** 2188284142
License/Permit # 0015052	**Permit Holder** Horizon Health, Inc.	**Purpose of Inspection** Full	**Est Type**	**Risk Category** M

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		X
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 Hygenic 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 proceedures 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		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		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) **Date:** 01/19/23

Inspector (Signature)