Electronically Delivered

February 23, 2024

Licensee
Duale Inc
1167 15th Avenue Southeast
Minneapolis, MN 55414

RE: Project Number(s) SL37655015

Dear Licensee:

On February 1, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the October 6, 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,

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

HHH

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

December 27, 2023

Licensee
Duale Inc
1167 15th Avenue Southeast
Minneapolis, MN 55414

RE: Project Number(s) SL37655015

Dear Licensee:

On November 14, 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 October 6, 2023. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the October 6, 2023 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on October 6, 2023, found not corrected at the time of the November 14, 2023, follow-up survey and/or subject to penalty assessment are as follows:

0250-Conditions-144g.20 Subdivision 1 - $500.00

The details of the violations noted at the time of this follow-up survey completed on November 14, 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.

Also, at the time of this follow-up survey completed on November 14, 2023, we identified the following violation(s):

0110-Assisted Living Director License Required-144g.10 Subdivision 1a - $500.00
0430-Uniform Checklist Disclosure Of Services-144g.40 Subd. 2
0450-Minimum Requirements-144g.41 Subdivision 1
0460-Minimum Requirements-144g.41 Subdivision 1
0470-Minimum Requirements-144g.41 Subdivision 1
0480-Minimum Requirements-144g.41 Subd 1 (13) (i) (b)
0495-Minimum Requirements-144g.41 Subd. 1 (14)
0580-Quality Management-144g.42 Subd. 2
0650-Employee Records-144g.42 Subd. 8
0660-Tuberculosis Prevention And Control-144g.42 Subd. 9
0680-Disaster Planning And Emergency Preparedness-144g.42 Subd. 10
0780-Fire Protection And Physical Environment-144g.45 Subd. 2 (a) (1)
0790-Fire Protection And Physical Environment-144g.45 Subd. 2 (a) (2)-(3)

0800-Fire Protection And Physical Environment-144g.45 Subd. 2 (a) (4)
0810-Fire Protection And Physical Environment-144g.45 Subd. 2 (b)-(f)
0900-Contract Required-144g.50 Subdivision 1
1290-Background Studies Required-144g.60 Subdivision 1
1500-Required Annual Training-144g.63 Subd. 5
1540-Training In Dementia Care Required-144g.64 (a)
1640-Service Plan, Implementation And Revisions To-144g.70 Subd. 4 (a-E)
1730-Individualized Medication Management Plan-144g.71 Subd. 5
1760-Documentation Of Administration Of Medication-144g.71 Subd. 8
1820-Prescriptions-144g.71 Subd. 13
3090-Notice To Visitors-144.6502, Subd. 8

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 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.

To submit a reconsideration request, please visit:

https://forms.web.health.state.mn.us/form/HRD-Appeals-Form

REQUESTING A HEARING

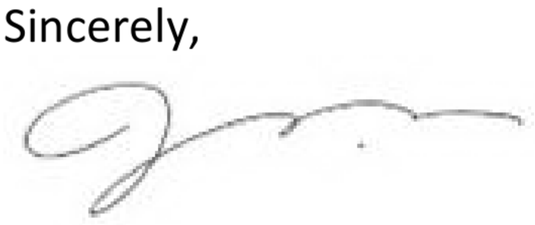
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for 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. 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. 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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37655	A. BUILDING: _____ B. WING _____	R 11/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUALE INC	1167 15TH AVENUE SE MINNEAPOLIS, MN 55414

(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: SL37655015-1 On November 13, 2023, through November 16, 2023, the Minnesota Department of Health conducted a follow up survey at the above provider, and the following correction orders are issued. At the time of the survey, there was one (1) active resident received services under the Assisted Living license. On November 16, 2023, at approximately 10:07 a.m. an immediate order was issued for 0495. At the time of exit, the immediacy was not removed.	{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 Provider. 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.	
0 110 SS=F	144G.10 Subdivision 1a Assisted living director license required Each assisted living facility must employ an	0 110		

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0 110	Continued From page 1 assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to employ a licensed assisted living director (LALD) licensed or permitted by the Board of Executives for Long Term Services and Supports (BELTSS). This had a potential to affect all the licensee's four residents receiving Assisted Living services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On November 13, 2023, at 9:45 a.m., during the entrance conference, owner (O)-A stated LALD-D was not available today. Also, O-A stated she called LALD-D and LALD-D was not answering phone calls. On November 13, 2023, at 11:00 a.m., during the entrance conference with O-A and manager (M)-C, the surveyor requested to see LALD-D's license. On November 13, 2023, at 12:00 p.m., O-A provided LALD-D's personal file. LALD-D's	0 110		

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0 110	Continued From page 2 license had expired on October 31, 2022. On November 13, 2023, at 4:59 p.m., O-A sent the surveyor via email an employee roster dated November 13, 2023, and LALD-D's name was not included on the employee roster. On November 16, 2023, at 7:28 a.m., O-A stated she was not able to reach LALD-D and she was looking for a new LALD. Page 2 (two) of the licensee's Application for Assisted Living Licensure signed August 22, 2023, by O-A, indicated LALD-D was the LALD for the licensee. On November 13, 2023, at 12:30 p.m., the Minnesota Board of Executives for Long-Term Services and Support (BELTSS) website was checked for verification of the assisted living director licensure verification. LALD-D was not listed as having a current LALD license. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
{0 250} SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in	{0 250}		

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{0 250}	Continued From page 3 this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency	{0 250}		

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{0 250}	Continued From page 4 level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the management officials who were in charge of the day-to-day operations; and responsible for the resident's assisted living services, understood all of the assisted living facility regulations. 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 of the residents). The findings include: The licensee's "Application for Assisted Living License", section titled "Official Verification of Owner or Authorized Agent", (page four and five of the application), identified, "I certify I have read and understand the following:" [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45 (opens in a new window), my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6,	{0 250}		

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{0 250}	Continued From page 5 sect. 17 (opens in a new window). - I have read and fully understand Minn. Stat. sect. 144G.80 (opens in a new window), 144G.81 (opens in a new window). and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22 (opens in a new window), my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G (opens in a new window). - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659 (proposed and not final) (opens in a new window). - Reporting of Maltreatment of Vulnerable Adults (opens in a new window). - Electronic Monitoring in Certain Facilities (opens in a new window)." - "I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G (opens in a new window), and Minnesota Rules, chapter 4659 (proposed and not final) (opens in a new window), governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence f a management agreement or subcontract." - "I have examined this application and all attachments, and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct and complete. I will notify MDH, in writing, of any changes to this information as required." - I attest to have all required policies and procedures of Minn. Stat. chapter 144G (opens in new window). and Minn. Rules chapter 4659 (proposed and not final) (opens in new window), in place upon licensure and to keep them current	{0 250}		

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{0 250}	Continued From page 6 as applicable." Page six was electronically signed by owner (O)-A on August 22, 2023. The licensee had an assisted living license effective November 1, 2023. Twenty-five (25) correction orders were issued, which indicated the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.01 to 144G.95. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	{0 250}		
0 430 SS=C	144G.40 Subd. 2 Uniform checklist disclosure of services (a) All assisted living facilities must provide to prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided	0 430		

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0 430	Continued From page 7 under paragraph (a). This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide a copy of the uniform checklist disclosure of services with the required content for the licensee's one current resident (R1). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R1 admitted for assisted living services on October 27, 2023. R1's record lacked a uniform checklist disclosure of services to include: - a disclosure of the categories of assisted living licenses available and the category of license held by the facility; - a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and - an oral explanation of all services offered under the contract On November 14,2023, at 8:45 a.m. unlicensed personnel (ULP)-B was observed to administer	0 430		

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0 430	Continued From page 8 oral medications to R1. On November 14, 2023, at 11:45 a.m. registered nurse (RN)-C and owner (O)-A stated R1 had not received a copy of the uniform checklist disclosure as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 430		
0 450 SS=C	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 ensure the current Minnesota Bill of Rights for Assisted Living Residents was provided to the resident and a written acknowledgement received for one of one resident (R1). This practice resulted in a level one violation (a	0 450		

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0 450	Continued From page 9 violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R1 admitted for assisted living services on October 27, 2023. On November 14,2023, at 8:45 a.m. unlicensed personnel (ULP)-B was observed to administer oral medications to R1. R1's record included a copy of the Minnesota Home Care Bill of Rights for Assisted Living Clients of Licensed Only Home Care Providers dated November 2019. On November 14, 2023, at approximately 11:45 a.m., registered nurse (RN)-C and owner (O)-A stated, "assisted living bill of rights was completed but papers got misplaced." O-A acknowledged R1 had not received the current Minnesota Bill of Rights for Assisted Living. 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;	0 460		

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0 460	Continued From page 10 (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 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 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. 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 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 the residents). The findings include: On November 13, 2023, at 11:00 a.m., owner (O)-A acknowledged the licensee lacked a system for residents to request assistance when	0 460		

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0 460	Continued From page 11 needed 24 hours a day. O-A stated staff are available to the residents at all times. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) 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 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;	0 470		

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0 470	Continued From page 12 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the required staffing plan was developed and posted as required. 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: The licensee failed to develop and implement a staffing plan for determining its staffing level based on the following: -each resident's needs, as identified in the resident's service plan and assisted living contract; -each resident's acuity level, as determined by the most recent assessment or individualized review; and -the ability of staff to timely meet the resident's scheduled and reasonably foreseeable unscheduled needs given the physical layout of the facility premises. On November 13, 2023, at 11:00 a.m., owner (O)-A confirmed a staffing plan had not been developed to address the content listed above and a daily staffing schedule was not posted. The licensee's Staffing policy dated August 1,	0 470		

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0 470	Continued From page 13 2021, indicated "The Clinical Nurse Supervisor will prepare and implement a 24-hour daily staffing plan that ensures adequate staffing to meet resident's needs at all times." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a 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	0 480		

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0 480	Continued From page 14 (FBEIR) dated November 13, 2023, 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		
0 495 SS=F	144G.41 Subd. 1 (14) Minimum Requirements (14) provide staff access to an on-call registered nurse 24 hours per day, seven days per week This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure staff had access to a registered nurse (RN) on-call 24 hours a day, seven days per week due to employment at a hospital. This had the potential to affect all residents and staff of the licensee. This resulted in an immediate correction order. 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: RN-C was hired on August 13, 2023. RN-C's Position Description - Clinical Nurse Supervisor dated and signed November 15, 2023,	0 495		

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0 495	Continued From page 15 after the initiation of the survey, indicated "nurse responds to clinical problems as identified by the unlicensed personnel." The licensee's undated employee roster indicated RN-C was the only RN employed by the licensee. On November 13, 2023, at 9:45 a.m., during the entrance conference, owner (O)-A stated RN-C was not available that day due to working a position at a hospital as a labor and delivery nurse. O-A stated RN-C's schedule was flexible, and RN-C worked three days a week for the licensee. On November 14, 2023, at 10:00 a.m., RN-C stated she was available to the licensee's staff three times a week. RN-C stated she worked at a hospital as a labor and delivery nurse. RN-C stated she may not be available to staff while assisting with a delivery but would check her phone when she was not busy. RN-C stated she was available to staff in the afternoons and her schedule was flexible. Also, RN-C stated she had no experience with assisted living facility licenses and had only worked at a hospital. On November 15, 2023, at 10:00 a.m., O-A stated RN-C was not available that morning because RN-C worked overnight last night at the hospital. O-A stated RN-C would be available in the afternoon. The licensee's Position Description - Clinical Nurse Supervisor, signed November 15, 2023, indicated, "Nurse responds to clinical problems as identified by the unlicensed personnel." No further information was provided.	0 495		

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0 495	Continued From page 16 TIME PERIOD FOR CORRECTION: IMMEDIATE The immediacy had not been removed by the time of exit.	0 495		
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 engage in and maintain documentation of quality management activities. 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:	0 580		

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0 580	Continued From page 17 On November 13, 2023, at 11:00 a.m., during the entrance conference, the licensee's quality management documentation was requested for review of any quality management activity. On November 15, 2023, at 11:45 a.m., owner (O)-A confirmed there was no current documentation of quality management activity. The licensee's Quality Improvement policy dated August 1, 2021, indicated "[Licensee] has established a quality improvement program based on the organization's size and appropriate to the type of services provided in order to assure that effective, comprehensive and appropriate plans are operational for all residents within the organization. The medication management program is an integral part of the overall quality improvement program." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 580		
0 650 SS=F	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency	0 650		

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0 650	Continued From page 18 evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the employee record contained the required content for two of two employees (unlicensed personnel (ULP)-B, registered nurse (RN)-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: ULP-B ULP-B was hired on June 11, 2021, and began providing assisted living cares to licensee's residents. ULP-B's record lacked evidence of the following:	0 650		

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0 650	Continued From page 19 - documentation of direct supervision by an RN within 30 days of ULP-B performing delegated nursing tasks, including medication administration; - documentation of annual performance reviews to identify areas of improvement needed and training needs; and - current job description, including qualifications, responsibilities, and identification of staff persons providing supervision. ULP-B's employee training records lacked evidence ULP-B successfully completed practical skills evaluations as required for training in accordance with assisted living 144G statutes in the following areas: -documentation requirements for all services provided; -reports of changes in the resident's condition to the supervisor designated by the facility; -basic infection control; -maintenance of a clean and safe environment; -appropriate and safe techniques in personal hygiene and grooming; -standby assistance techniques and how to perform them; -medication, exercise, and treatment reminders; -basic nutrition, meal preparation, food safety, and assistance with eating; -preparation of modified diets as ordered by a licensed health professional; -communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; -awareness of confidentiality and privacy; -understanding of appropriate boundaries between staff and residents and the resident's family; -procedures to use in handling various	0 650		

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0 650	Continued From page 20 emergency situations; and -awareness of commonly used health technology equipment and assistive devices. ULP-B's employee training record lacked evidence to indicate the employee had received orientation to include the following topics: - an overview of Assisted Living laws 144G; - 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. RN-C RN-C was hired on August 31, 2022, and began providing assisted living cares to licensee's residents.	0 650		

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0 650	Continued From page 21 RN-C's record lacked evidence of the following: -documentation of annual performance reviews to identify areas of improvement needed and training needs. RN-C's employee training record lacked evidence to indicate the employee had received orientation to include the following topics: - an overview of Assisted Living laws 144G; - 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, 2023, at 8:40 a.m. ULP-B stated they had been trained practical skills evaluations as required by another nurse who is no longer with licensee's.	0 650		

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0 650	Continued From page 22 On November 14, 2023, at 11:45 a.m., owner (O)-A verified the above contents were missing from the employee records. During a follow-up interview on November 15, 2023, at 11:45 a.m., O-A stated a different nurse had been employed by the licensee before RN-C, and ULP-B's practical skills evaluations was completed as required, but no documentation was available. Owner (O)-A stated ULP-B's record did not include 30-days supervision of medication administration or other delegated tasks. O-A stated the 30-day supervision was completed but misplaced. O-A verified ULP-B and RN-C's records lacked orientation to assisted living licensing requirements and regulations. O-A stated they completed the required orientation to assisted living licensing but misplaced the documents. The licensee's Personnel Records policy dated August 1, 2021, indicated records must include, but were not limited to current job description, performance reviews, and orientation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control	0 660		

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0 660	Continued From page 23 and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) when the licensee failed to ensure a two-step tuberculin skin test (TST) or other blood test was completed upon hire for two of two employees (unlicensed personnel (ULP)-B, registered nurse (RN)-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: The licensee's TB risk assessment dated January 1, 2023, indicated the facility was at a low risk for TB transmission.	0 660		

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0 660	Continued From page 24 ULP-B ULP-B was hired on June 11, 2021, and began providing assisted living cares to licensee's residents. ULP-B's record included a TST dated October 14, 2023. ULP-B's record lacked documentation TB history and symptom screening upon hire. RN-C RN-C was hired on August 31, 2022, and began providing assisted living cares to licensee's residents. RN-C's employee record included a TB history and symptom screening completed June 3, 2022, and a chest x-ray completed March 23, 2021. RN-C's record lacked the required TB testing by blood test dated prior to the date of the chest x-ray within 90 days of hire. On November 15, 2023, at 11:45 a.m., owner (O)-A confirmed ULP-B's record lacked documentation TB history and symptoms screening by the licensee upon hire and RN-C's TB testing by blood test or chest x-ray within 90 days of hire. The Minnesota Department of Health (MDH) guidelines Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, and based on CDC guidelines, indicated a TB infection control program should include an annual facility TB risk assessment. The guidelines also indicated an employee may begin working with patients (residents) after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be	0 660		

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	37655	A. BUILDING: _____ B. WING _____	R 11/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUALE INC	1167 15TH AVENUE SE MINNEAPOLIS, MN 55414

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0 660	Continued From page 25 performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record." The licensee's 8.16 Tuberculosis Screening/Prevention policy dated August 1, 2023, indicated baseline screenings at time of hire for all direct care providers and anyone who visits residents (including volunteers). Screening will be conducted as follows: - Employees receive baseline TB screening upon hire to test for infection with M. tuberculosis; and -The baseline test may be either (2-step) or BAMT. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents.	0 680		

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	37655	A. BUILDING: _____ B. WING _____	R 11/14/2023

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0 680	Continued From page 26 (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 have a written emergency preparedness plan with all of the required content and failed to post an emergency preparedness plan prominently. This had the potential to affect all residents receiving services under the assisted living license, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On November 13, 2023, at 11:10 a.m., during a facility tour, the surveyor did not observe evidence of signage posted or information regarding the licensee's emergency plan. There were no emergency exit diagrams posted in conspicuous places on each floor, and no	0 680		

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0 680	Continued From page 27 emergency exit diagrams as required. On November 13, 2023, at 3:48 p.m., owner (O)-A emailed an undated copy of the licensee's Emergency Preparedness plan. The licensee's plan lacked evidence of the following required content: - a comprehensive program to include infectious diseases and pandemics; - a description of the population served by the licensee; - process for emergency preparedness (EP) cooperation with state and local EP officials/organizations; - procedure for tracking staff and residents; - subsistence needs for staff and residents during emergency situation; - a communication plan that included: - contact information for federal, state, tribal, local EP staff, ombudsman; - primary and alternative means for communicating with facility staff, federal, state, regional and local emergency management agencies; - a method of sharing information and medical documentation for residents; - a means to provide information regarding the facility's needs, and its ability to provide assistance to include information about their occupancy; -a method of sharing information from the emergency plan with residents and their families; - EP training and testing program; - EP training program for staff (including documentation of training provided); and - EP testing/annual testing requirements. On November 15, 2023, at 11:45 a.m., O-A verified the licensee had not fully developed and implemented emergency preparedness plan with	0 680		

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0 680	Continued From page 28 all of the required content and failed to post an emergency preparedness plan prominently. The licensee's Emergency Preparedness policy dated August 1, 2021, indicated [Licensee] would have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 780 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	0 780		

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0 780	Continued From page 29 smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that are interconnected so the actuation of one alarm causes all alarms in the dwelling unit to actuate. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On November 13, 2023, from 10:00 a.m. to 11:15 a.m., survey staff toured the facility with manager (M)-C. It was observed the sleeping rooms that were equipped with smoke alarms were not interconnected with the other smoke alarms in the dwelling unit so the actuation of one alarm would cause all alarms to operate. The only interconnected smoke alarms in the facility were located in the living room area of the main level and upper level. There was no smoke alarm located in the basement which had the laundry area, furnace area, and office. Each story of a house must have	0 780		

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0 780	Continued From page 30 an interconnected smoke alarm installed. This deficient condition was visually verified by M-C accompanying on the tour. During interview on November 13, 2023 at 11:15 a.m., M-C stated they did not understand all the smoke alarms had to be interconnected and did not realize the basement did not have a smoke alarm installed. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
0 790 SS=D	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure maintenance of portable fire extinguishers at the facility. 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	0 790		

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0 790	Continued From page 31 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, 2023, from 10:00 a.m. to 11:15 a.m., survey staff toured the facility with manager (M)-C. During the facility tour, survey staff observed the fire extinguishers in the kitchen was sitting on the floor and did not have an inspection tag where monthly inspections were being completed. On November 13, 2023, at 11:15 a.m., M-C verbally confirmed survey staff observations during the facility tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
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:	0 800		

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0 800	Continued From page 32 Based on observation and interview, the licensee failed to maintain 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. 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). The findings include: On November 13, 2023, from 10:00 a.m. to 11:15 a.m., survey staff toured the facility with owner (O)-A and manager (M)-C. It was observed the egress windows in bedroom #2 needed maintenance and did not function properly. The window would not open. O-A stated the windows had recently been painted and she thought it may be stuck because of that. Survey staff explained to O-A and M-C no resident should be moved into bedroom #2 until the windows were able to function properly. Further observations of disrepair included: The back egress stairs from the second floor had unfinished walls with hundreds of nails protruding into the stairwell space. The main level bathroom had water damage around the sink area where the wood wainscot	0 800		

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0 800	Continued From page 33 material was warped and pulled away from the wall leaving a large gap for potential water peneration into the wall material. The main level bathroom floor by the toilet also had signs of water damage and was soft/squishy when stepped on. M-C stated they had recently had plumbing work done due to a leak in that same area, but he didn't realize the floor was damaged. There was an office in the basement of the house. The exit path from the office to the exterior of the building was obstructed as it passed through the storage space between the office and laundry area. Anyone exiting from the office would need to pass through the storage space that was filled with miscellaneous garbage, building materials, and broken/damaged ceiling tiles and grid pieces that hung down from the ceiling into the exit path. Exit paths must be maintained and clear of obstructions. On November 13, 2023, from 10:00 a.m. to 11:15 a.m., O-A and M-C verified these deficient findings at the time of discovery. TIME PERIOD FOR CORRECTION: Twenty-One (21) 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	0 810		

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0 810	Continued From page 34 a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year 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 observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content, make the plan readily available, and provide required training and 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	0 810		

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0 810	Continued From page 35 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: During observation on November 13, 2023, at 10:00 a.m., the surveyor observed the fire safety and evacuation plan was not located in a central location for all staff to access. It was also observed there were no posted evacuation plans or diagrams in the facility. On November 13, 2023, manager (M)-C provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee FSEP dated July 2021, failed to include the following: The location and/or number of resident sleeping rooms. No exit diagrams were included in the policy manual. The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The FSEP did not identify specific fire protection actions for residents. The FSEP did not include specific resident actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks.	0 810		

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0 810	Continued From page 36 The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. During an interview on November 13, 2023, at 12:30 p.m., M-C stated they had not modified the policy they purchased from a third party to fit their specific building layout, resident capacity, or staffing model. TRAINING Record review indicated the licensee failed to provide evacuation training to residents at least once per year as evidenced by no documentation available to review upon request. Record review indicated the licensee failed to provide training to employees on the FSEP upon hire and/or at least twice per year as evidenced by no documentation available to review upon request. During an interview on November 13, 2023, at 12:30 p.m., M-C stated they had completed the training required, but did not have the documentation. DRILLS Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month as evidenced by the fire drill log kept on site. Fire Drill Log had one drill documented on November 5, 2023, and no other drills documented.	0 810		

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0 810	Continued From page 37 During an interview on November 13, 2023, at 12:30 p.m., M-C stated that they had not done any other evacuation drills. 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. (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	0 900		

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0 900	Continued From page 38 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 execute an Assisted Living contract to include all required content for one of one resident. 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: R1 admitted for assisted living services on October 27, 2023. R1's record lacked a written contract with the following required content: (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	0 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37655	A. BUILDING: _____ B. WING _____	R 11/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUALE INC	1167 15TH AVENUE SE MINNEAPOLIS, MN 55414

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0 900	Continued From page 39 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. On November 14, 2022, at 11:45 a.m., owner (O)-A confirmed an assisted living contract to include all required content had not been developed or implemented for R1. On November 16, 2023, at 7:21 a.m., O-A emailed copy of R1's Assisted Living contract signed November 14, 2023, after initiation of the survey. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 900		
01290 SS=D	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section	01290		

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01290	Continued From page 40 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a background study was affiliated to the licensee's health facility identification number (HFID) prior to providing services to residents for one of two employees (unlicensed personnel (ULP)-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: ULP-B had a hire date of June 11, 2021, to provide direct care services to the licensee's residents. On November 14, 2023, at 8:45 a.m., ULP-B was observed administering medications to R1.	01290		

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01290	Continued From page 41 ULP-B's employee record contained a background study dated June 11, 2021, affiliated to licensee's former HFID 36113. ULP-B's employee record lacked evidence the licensee affiliated a background study for ULP-B under the current HFID. On November 15, 2023, at 11:45 a.m., owner (O)-A stated the licensee had not affiliated ULP-B's background study to the current HFID. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment;	01500		

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01500	Continued From page 42 disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employees	01500		

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01500	Continued From page 43 received at least eight hours of annual training for each 12 months of employment for two of two employees (unlicensed personnel (ULP)-B, registered nurse (RN)-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: ULP-B ULP-B was hired on June 11, 2021, under the comprehensive home care license. ULP-B began providing assisted living services after August 1, 2021. On November 14, 2023, at 8:45 a.m., ULP-B was observed administering medications to R1. RN-C RN-C was hired on August 31, 2022, and began providing assisted living cares to licensee's residents. ULP-B and RN-C's employee training records lacked evidence ULP-B and RN-C had successfully completed annual training as required in the following areas: -training on reporting of maltreatment of vulnerable adults under section 626.557; -review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;	01500		

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01500	Continued From page 44 -review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; -effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; -review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. During interview on November 15, 2023, at 11:45 a.m., owner (O)-A confirmed ULP-B and RN-C's records lacked annual training. The licensee's Personnel Records policy dated August 1, 2021, indicated records of annual training will be maintained. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		
01540 SS=F	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED	01540		

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01540	Continued From page 45 (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure all staff received eight hours of initial dementia care training within the first 120 working hours of employment for supervisors of direct care staff and within the first 160 working hours of employment for direct care employees as required for two of two employees (unlicensed personnel (ULP)-B, registered nurse (RN)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	01540		

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01540	Continued From page 46 The findings include: ULP-B ULP-B was hired on June 11, 2021, under the comprehensive home care license. ULP-B began providing assisted living services after August 1, 2021. ULP-B's employee record lacked documentation ULP-B completed the initial eight hours of training required related to dementia care within 160 working hours of ULP-B's employment start date. RN-C RN-C was hired on August 31, 2022, and began providing assisted living cares to licensee's residents. RN-C's employee record lacked documentation RN-C completed the initial eight hours of training required related to dementia care within 120 working hours of RN-C's employment start date. During interview on November 15, 2023, at 11:45 a.m., owner (O)-A confirmed RN-C and ULP's records lacked the required eight (8) hours of dementia care trainings. O-A stated ULP-B and RN-C completed dementia care trainings, but documentation got misplaced. Also, O-A stated all staff have assigned dementia training through the online program EduCare, but O-A verified RN-C's and ULP-B's records lacked evidence that were completed within the required time frame. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01540		

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01640	Continued From page 47	01640		
01640 SS=F	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 finalize a current written service plan within 14 calendar days for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all	01640		

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01640	Continued From page 48 of the residents). The findings include: R1 admitted for assisted living services on October 27, 2023. R1's undated Charting Sheet indicated R1 received services including assistance with medication management, meals, dressing, activity, and behavior management. R1's record lacked a signed service plan with the following required content: (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 On November 15, 2023, at 10:30 a.m., R1 stated he did not sign a service plan.	01640		

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01640	Continued From page 49 On November 14, 2023, at 12:00 p.m., owner (O)-A and registered nurse (RN)-C verified R1's record lacked a signed service plan with the required content. Also, O-A and RN-C stated, "service plan was completed, but papers got misplaced." The licensee's Service Plan policy dated August 1, 2021, indicated "All residents receiving assisted living services will have a service plan in place." The policy further indicated, "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." The policy further indicated the service plan would include: a. A description of the services 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 provide services e. A schedule and method for the next planned assessment or monitoring; f. A schedule and method for the next planned monitoring of staff providing services; and 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	01640		

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01640	Continued From page 50 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. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01640		
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	01730		

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01730	Continued From page 51 nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an individualized medication management plan with the 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 admitted for assisted living services on October 27, 2023, with diagnoses including hypertension (high blood pressure).	01730		

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DUALE INC	1167 15TH AVENUE SE MINNEAPOLIS, MN 55414

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01730	Continued From page 52 On November 14, 2023, at 8:45 a.m., ULP-B was observed administering medications to R1. R1's record lacked individual medication management plan content to include; (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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37655	A. BUILDING: _____ B. WING _____	R 11/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUALE INC	1167 15TH AVENUE SE MINNEAPOLIS, MN 55414

(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 53 (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. (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. On November 14, 2022, at 11:45 a.m., registered nurse (RN)-C acknowledged R1's record lacked an individualized medication management plan with the required content. RN-C stated they were not aware of the required content listed above. The licensee's Assessment of Medications policy dated August 1, 2021, indicated prior to providing medication management services, [licensee] will provide an assessment by a RN to determine what medication management services will be provided and how they will be implemented No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37655	A. BUILDING: _____ B. WING _____	R 11/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUALE INC	1167 15TH AVENUE SE MINNEAPOLIS, MN 55414

(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 SS=F	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 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 the documentation included the signature and title of the person who administered the medication for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 admitted for assisted living services on October 27, 2023.	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37655	A. BUILDING: _____ B. WING _____	R 11/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUALE INC	1167 15TH AVENUE SE MINNEAPOLIS, MN 55414

(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 55 On November 14, 2023, at 8:45 a.m., ULP-B was observed administering medications to R1. R1's record's include Medication Administration Record (MAR), dated October and November 2023. R1's MARs indicated the following medications were administered from October 28 to November 14, 2023. - Melatonin 3 milligram (mg) - 1 tablet po daily - Cyclobenzaprine 5 mg - 1 tablet by mouth three times daily - Last day given November 6, 2023 - Lisinopril (Prinivil: Zestril) 20 mg - one tablet by mouth daily - Acetaminophen 325 mg - two tablet by mouth every 6 hours - Sennosides 8.6 mg - 1 tab by mouth twice daily - Oxycodone 5 mg - 1 tablet by mouth every four hours as needed - last given November 6, 2023 R1's record lacked the documentation included the signature and title of the person who administered the medication. On November 14, 2022, at 11:45 a.m., registered nurse (RN)-C acknowledged R1's MAR lacked documentation including the signature and title of the person who administered the medication. RN-C also stated she had trained staff to include their names and titles for residents' MARs. The licensee's Medication Documentation policy dated August 1, 2021, indicated each medication administered by [licensee] staff will be documented in the resident's clinical record. Documentation will be complete, accurate and legible. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37655	A. BUILDING: _____ B. WING _____	R 11/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUALE INC	1167 15TH AVENUE SE MINNEAPOLIS, MN 55414

(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 56 days	01760		
01820 SS=F	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 written or electronically recorded prescriptions were obtained for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 admitted for assisted living services on October 27, 2023, with diagnoses including hypertension (high blood pressure). On November 14, 2023, at 8:45 a.m., surveyor observed unlicensed personal (ULP)-B administer medications to R1. ULP-B stated they were administering medications R1 brought from the hospital after R1 discharged, and they run out some of the medications this morning, so ULP-B administered only the following medications:	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37655	A. BUILDING: _____ B. WING _____	R 11/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUALE INC	1167 15TH AVENUE SE MINNEAPOLIS, MN 55414

(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 57 - Lisinopril (Prinivil: Zestril) 20 milligram (mg) - one tablet by mouth daily - Acetaminophen 325 mg - two tablet by mouth every 6 hours R1's medical record lacked signed prescription orders. During an interview on November 14, 2021, at 11:45 a.m., registered nurse (RN)-C verified R1's medical record lacked signed prescription orders. RN-C stated that they faxed R1's doctor and is waiting for a response. The licensee's Prescriber's Orders policy dated August 1, 2021, indicated written orders from an authorized prescriber will be obtained for all the medications and treatments with which the assisted living facility assisted residents, including over the counter medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37655	A. BUILDING: _____ B. WING _____	R 11/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUALE INC	1167 15TH AVENUE SE MINNEAPOLIS, MN 55414

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03090	Continued From page 58 Based on observation, interview, and record review, the licensee failed to ensure a required notice was posted at each entry way of the facility to display statutory language to disclose the potential for electronic monitoring activity. This had the potential to affect all residents, staff, and visitors to the facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On November 13, 2023, at 9:45 a.m., upon entering the facility, the surveyor observed no electronic monitoring notice posted in the facility with the statutory required language. On November 15, 2023, at 11:45 a.m., owner (O)-A confirmed no posting was available related to the statutory language for electronic monitoring. The licensee's Electronic Monitoring policy dated August 1, 2021, indicated the [licensee] would post a sign at each facility entrance that states, "electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37655	A. BUILDING: _____ B. WING _____	R 11/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUALE INC	1167 15TH AVENUE SE MINNEAPOLIS, MN 55414

(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

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

Type: Follow-Up
Date: *11/29/23*
Time: 10:30:34
Report: 1021231391

Food and Beverage Establishment Inspection Report

Location:
Duale Inc
1167 15th Avenue Se
Minneapolis, MN55414
Hennepin County, 27

Establishment Info:
ID #: 0038203
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 6126448831
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 previously issued on 11/13/23 have NOT been corrected.

4-700 Sanitizing Equipment and Utensils

4-702.11 ***** Priority 1 *****

MN Rule 4626.0900 Sanitize utensils and food contact surfaces of equipment before use, after cleaning.

ESTABLISHMENT DID NOT HAVE A WAY TO SANITIZE DISHES AND UTENSILS. NO THREE COMPARTMENT SINK OR DISH MACHINE ON-SITE. DISCUSSED WITH OWNER THAT ALL UTENSILS AND FOOD CONTACT SURFACES SHOULD BE SANITIZED AFTER EACH USE. SEE COMMENTS. REPEAT 11/29/23.

Issued on: 11/13/23 *Comply By: 02/01/24*

2-100 Supervision

2-102.12AMN

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

NO CERTIFIED FOOD PROTECTION MANAGER (CFPM) WAS EMPLOYED AT THIS ESTABLISHMENT. OWNER HAS A FOOD SAFETY CERTIFICATE ON-SITE BUT SHE IS WAITING FOR HER CFPM CERTIFICATE. POST CFPM CERTIFICATE ONCE IT IS RECEIVED. REPEAT 11/29/23.

Issued on: 11/13/23 *Comply By: 11/24/23*

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Chlorine: = 100PPM at Degrees Fahrenheit
Location: SANI SPRAY BOTTLE
Violation Issued: No

Type: Follow-Up
Date: *11/29/23*
Time: 10:30:34
Report: 1021231391
Duale Inc

Food and Beverage Establishment Inspection Report

Chlorine: = 50PPM at Degrees Fahrenheit
Location: SANITIZER CONTAINER FOR DISHWASHING
Violation Issued: No

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

TODAY'S FOLLOW UP WAS TO ADDRESS AND CLEAR PREVIOUSLY WRITTEN ORDERS FROM A FULL INSPECTION CONDUCTED ON 11/13/23. 8 OUT OF 10 ORDERS WERE CLEARED FROM THE REPORT.

CONTINUATION OF MN Rule 4626.0900
ESTABLISHMENT IS USING A CONTAINER BIG ENOUGH TO FIT THE BIGGEST PAN/UTENSILWITH AN APPROVED CHLORINE SANITIZING SOLUTION. THIS IS NOT A PERMANENT SOLUTION BUT THEY CAN USE IT IN THE MEANTIME THEY GET A WAY TO SANITIZE.

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 1021231391 of 11/29/23.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Inspection report reviewed with person in charge and emailed.

Signed:_____
ISTAHIL ABDI
OWNER

Signed:_____
Melissa Ramos
Environmental Health Specialist
Metro District Office
651-201-4495
Melissa.Ramos@state.mn.us

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

Type: Full
Date: *11/13/23*
Time: 12:38:59
Report: 1021231375

Food and Beverage Establishment Inspection Report

Location:
Duale Inc
1167 15th Avenue Se
Minneapolis, MN55414
Hennepin County, 27

Establishment Info:
ID #: 0038203
Risk:
Announced Inspection: Yes

License Categories:

Expires on: 07/01/24

Operator:

Phone #: 6126448831
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 EMPLOYEE ILLNESS LOG ON-SITE. DISCUSSED EMPLOYEE ILLNESS POLICY AND RECORDING WITH OWNER. AN MDH EMPLOYEE ILLNESS LOG SENT WITH REPORT.

Comply By: 11/15/23

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.

A CARTON OF RAW SHELL EGGS FOUND STORED ABOVE READY TO EAT CARROTS AND A COUPLE CONTAINERS OF JUICE IN THE KITCHEN FRIGIDAIRE REFRIGERATOR. OWNER MOVED CARTON OF RAW SHELL EGGS TO BOTTOM SHELF DURING INSPECTION. CORRECTED ON-SITE.

Comply By: 11/13/23

4-700 Sanitizing Equipment and Utensils

4-702.11 ***** Priority 1 *****

MN Rule 4626.0900 Sanitize utensils and food contact surfaces of equipment before use, after cleaning.

ESTABLISHMENT DID NOT HAVE A WAY TO SANITIZE DISHES AND UTENSILS. NO THREE COMPARTMENT SINK OR DISH MACHINE ON-SITE. DISCUSSED WITH OWNER THAT ALL UTENSILS AND FOOD CONTACT SURFACES SHOULD BE SANITIZED AFTER EACH USE. SEE

COMMENTS.
Comply By: 02/01/24

7-200 Toxic Supplies and Applications

7-204.11 ***** Priority 1 *****

MN Rule 4626.1620 Discontinue using chemical sanitizers, including chemical sanitizing solutions generated on site and other chemical antimicrobials on food-contact surfaces that do not meet the requirements specified in 40 CFR part 180, section 180.940, or part 180, subpart E, section 180.2020.

CHLORINE CONCENTRATION IN KITCHEN SANITIZER SPRAY BOTTLE MEASURED ABOVE 200PPM. SANI SPRAY BOTTLE WAS CORRECTED TO 100PPM DURING INSPECTION. CORRECTED ON-SITE.

Comply By: 11/13/23

2-500 Responding to contamination events

2-501.11 ***** Priority 2 *****

MN Rule 4626.0123 Provide employees with procedures to follow for cleanup of vomit or fecal matter in the establishment. The procedures must minimize the spread of contamination to food and surfaces within the facility, and minimize the exposure of employees and consumers to contamination.

ESTABLISHMENT DOES NOT HAVE PROCEDURES IN PLACE ON HOW TO CLEAN UP A VOMITING/FECAL ACCIDENT. INFORMATION ON HOW TO PROPERLY CLEAN UP AN ACCIDENT SENT WITH REPORT. TRAIN EMPLOYEES TO CLEAN UP ACCIDENTS.

Comply By: 11/20/23

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 THE KITCHEN HANDWASHING SINK. OWNER PROVIDED PAPER TOWELS DURING INSPECTION. CORRECTED ON-SITE. COMPLY WITH RULE ABOVE.

Comply By: 11/13/23

7-100 Toxic Labeling

7-102.11 ***** Priority 2 *****

MN Rule 4626.1595 Clearly label all working containers used for storing poisonous or toxic materials from bulk supplies such as sanitizers and cleaners, with the common name of the product.

CHLORINE SANI SPRAY BOTTLE IN KITCHEN WAS FOUND WITH NO LABEL. LABEL SANI SPRAY BOTTLE WITH THE COMMON NAME OF THE PRODUCT AS DESCRIBED IN RULE ABOVE.

Comply By: 11/15/23

2-100 Supervision

2-102.12AMN

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

NO CERTIFIED FOOD PROTECTION MANAGER (CFPM) WAS EMPLOYED AT THIS ESTABLISHMENT. OWNER HAS A FOOD SAFETY CERTIFICATE ON-SITE BUT SHE IS WAITING FOR HER CFPM CERTIFICATE. POST CFPM CERTIFICATE ONCE IT IS RECEIVED.

Comply By: 11/24/23

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

THE HANDWASHING SINK IN THE UPSTAIRS EMPLOYEE BATHROOM IS MISSING A HANDWASHING SIGN/POSTER THAT REMINDS FOOD EMPLOYEES TO WASH HANDS BEFORE RETURNING TO WORK. PROVIDE AS DESCRIBED IN RULE ABOVE.

Comply By: 11/15/23

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.16

MN Rule 4626.1540 Hang mops to dry after each use and do not store mops in a manner that will soil walls, equipment or supplies.

MOP BUCKET IN THE KITCHEN CONTAINED DIRTY WATER AND THE MOP WAS FOUND STORED INSIDE THE MOP BUCKET. COMPLY WITH RULE ABOVE. OWNER WILL HANG MOP TO AIR DRY.

Comply By: 11/13/23

Surface and Equipment Sanitizers

Chlorine: = 50PPM at Degrees Fahrenheit
Location: SANI BUCKET
Violation Issued: No

Chlorine: > 200PPM at Degrees Fahrenheit
Location: SANI SPRAY BOTTLE
Violation Issued: Yes

Chlorine: = 100PPM at Degrees Fahrenheit
Location: SANI SPRAY BOTTLE *CORRECTED
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Ambient Temperature
Temperature: 39 Degrees Fahrenheit - Location: FRIGIDAIRE REFRIGERATOR
Violation Issued: No

Food and Beverage Establishment Inspection Report

Process/Item: Cold Holding
Temperature: 41 Degrees Fahrenheit - Location: MILK - FRIGIDAIRE REFRIGERATOR
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	4	3	3

ALL FINDINGS ON THIS REPORT WERE DISCUSSED WITH OWNER, ISTAHIL ABDI AND HEALTH REGULATION DIVISION NURSE EVALUATOR, SAFIA HASSAN.

THIS FACILITY IS A RESIDENTIAL HOME AND THEY CURRENTLY HAVE 1 CLIENT AND THE FACILITY CAN HAVE UP TO 4 CLIENTS.

PER CONVERSATION WITH ISTAHIL, FOOD IS MADE FOR SAME DAY SERVICE. NO LEFTOVERS ARE KEPT.

CONTINUATION OF MN Rule 4626.0900
ESTABLISHMENT WILL USE A CONTAINER BIG ENOUGH TO FIT THE BIGGEST PAN/UTENSIL WITH AN APPROVED CHLORINE SANITIZING SOLUTION. DISCUSSED WITH OWNER THAT STAFF CAN WASH AND RINSE IN THE TWO COMPARTMENT SINK, AND THEY HAVE TO MANUALLY SANITIZE IN THE SANITIZER CONTAINER. THIS IS NOT A PERMANENT SOLUTION BUT THEY CAN USE IT IN THE MEANTIME THEY GET A WAY TO SANITIZE. DISCUSSED DIFFERENT OPTIONS DURING INSPECTION.

THE KITCHEN HAS RESIDENTIAL EQUIPMENT, VINYL FLOORING, LAMINATE COUNTERTOPS AND PAINTED DRYWALL. PHYSICAL FACILITY ITEMS WILL BE MONITORED AT FUTURE INSPECTIONS.

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 1021231375 of 11/13/23.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/__/____

Inspection report reviewed with person in charge and emailed.

Signed:_____
ISTAHIL ABDI
OWNER

Signed:_____
Melissa Ramos
Environmental Health Specialist
Metro District Office
651-201-4495
Melissa.Ramos@state.mn.us

Electronically Delivered

October 26, 2023

Licensee
Duale Inc
1167 15th Avenue Southeast
Minneapolis, MN 55414

RE: Project Number(s) SL37655015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on October 6, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the 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. The MDH documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

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

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

The correction order documentation should include the following:

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

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

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,

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State Evaluation Team
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HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37655	A. BUILDING: _____ B. WING _____	10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUALE INC	1167 15TH AVENUE SE MINNEAPOLIS, MN 55414

(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: SL37655015 On October 02, 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 was no resident receiving services under the Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Provider. 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.	
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a	0 250		

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0 250	Continued From page 1 result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under	0 250		

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0 250	Continued From page 2 section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to cooperate with a survey as required by chapter 144G.20 Subdivision 1. 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 October 2, 2023, at 8:00 a.m., the surveyor sent email notification to the licensee announcing the survey. On October 2, 2023, at 8:10 a.m., the surveyor spoke with the owner (O)-A over the phone. O-A	0 250		

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0 250	Continued From page 3 stated the licensee would like to reschedule the survey because the owner and the registered nurse are out of the state for vacation, and they have no residents at this time. On October 2, 2023, at 8:18 a.m., the survey supervisor spoke with O-A over the phone. O-A stated they were out of town, the nurse was out of town, and no one would be available to meet the surveyor onsite to complete a survey. O-A stated the licensee had no current residents and asked if the survey could be rescheduled. The survey supervisor told O-A that survey work is unannounced and would proceed as scheduled and informed O-A that the surveyor would arrive onsite by 10:00 a.m. for the survey. On October 2, 2023, at 9:47 a.m., the surveyor observed no cars in the licensee's driveway. The surveyor knocked at the door and rang the doorbell with no response. On October 2, 2023, at 10:00 a.m., the surveyor knocked at the door and rang the doorbell with no response. On October 2, 2023, at 10:15 a.m., the surveyor knocked at the door again and rang the doorbell with no response. On October 2, 2023, at 10:30 a.m., the surveyor left the licensee's facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250		