DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

March 6, 2023

Licensee
Suite Living Senior Care of Brooklyn Park
8500 Regent Avenue North
Brooklyn Park, MN 55443

RE: Project Number(s) SL36600015

Dear Licensee:

On February 8, 2023, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the December 1, 2022, evaluation were corrected. This follow-up evaluation verified that the facility is in substantial compliance.

It is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. You are encouraged to retain this document for your records.

Please feel free to call me with any questions.

Sincerely,

Jess Schoenecker, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: Jess.Schoenecker@state.mn.us
Phone: 651-201-3789 Fax: 651-215-9697

HHH

Electronically Delivered

December 23, 2022

Licensee
Suite Living Senior Care of Brooklyn Park, LLC
8500 Regent Avenue North
Brooklyn Park, MN 55443

RE: Project Number(s) SL36600015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on December 1, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

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

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

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

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00
St - 0 - 1750 - 144g.71 Subd. 7 - Delegation Of Medication Administration - $3,000.00

The total amount you are assessed is $3,500.00. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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

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

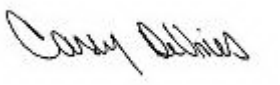
REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

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

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

Sincerely,



Casey DeVries, Supervisor
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Phone: 651-201-5917 Fax: 651-215-6894

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36600	A. BUILDING: _____ B. WING _____	12/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUITE LIVING SR CARE OF BP	8500 REGENT AVENUE NORTH BROOKLYN PARK, MN 55443

(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 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: SL3660015-0 On November 28, 2022, through December 1, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 23 residents, all of whom received services under the provider's Assisted Living with Dementia Care license. It was determined upon supervisory review, the licensee's practice related to the delegation of medications was non-compliant. This practice resulted in the issuance of an immediate order for correction, tag identification 1750, on December 20, 2022, at approximately 4:00 p.m. On December 21, 2022, the immediacy of correction order 1750 was removed, however, non-compliance remained at a level 3, scope of widespread violation.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	

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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; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the staffing plan was posted for residents, staff, and visitors to review as required. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a	0 470		

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0 470	Continued From page 2 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 28, 2022, at 9:20 a.m., during a facility tour, the surveyor observed a posted staff schedule dated November 21, 2022, through November 27, 2022, which lacked information for November 28, 2022, staff schedule. On November 29, 2022, at 6:40 a.m., and November 30, 2022, at 9:00 a.m., during facility tour, the surveyor did not observe a posted staff schedule in any area of the facility developed by the clinical nurse supervisor to: - include direct-care staff work schedules for each direct-care staff member showing all work shifts, including days and hours worked; - identify the direct-care staff member's resident assignments or work location; and - be posted after redacting direct-care staff member's resident assignments, at the beginning of each work shift in a central location. On November 28, 2022, at 9:42 a.m., housing director (HD)-D stated the staff schedule was not updated because it was a Monday, however, HD-D was updating the posting. On November 30, 2022, at 9:37 a.m., registered nurse (RN)-A stated the posting for staff schedule was the responsibility of HD-D. In addition, RN-A stated staff schedules were in a binder behind the	0 470		

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0 470	Continued From page 3 nursing station and could be accessed by staff, residents, and visitors upon request. 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: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared according to the Minnesota Food Code. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 480		

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0 480	Continued From page 4 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: Please refer to the additional documentation included in the Food and Beverage Establishment Inspection Reports, dated November 29, 2022. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to establish and maintain an effective infection control program to comply with accepted health care, medical, and nursing standards for infection control. This	0 510		

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0 510	Continued From page 5 practice had the potential to affect the licensee's residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: HAND HYGIENE On November 29, 2022, at approximately 7:53 a.m., during breakfast in a common area, the surveyor observed activities director (AD)-I performed no hand hygiene prior to serving beverages and meals to five residents. On November 29, 2022, at approximately 7:59 a.m., the surveyor observed AD-I assist a resident seated in their wheelchair to the table, then don gloves without completing hand hygiene, and prepare beverages for five residents in the common dining room. On November 30, 2022, at approximately 9:38 a.m., registered nurse (RN)-A stated staff were expected to wash their hands before and after medication pass, delegated tasks, toileting, meals, in between residents, and when hands were soiled. The licensee's Hand Washing policy dated July 20, 2021, indicated hand washing would be completed with the following: -Before, during, and after preparing food; -Before eating food;	0 510		

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0 510	Continued From page 6 -Before and after caring for someone who is sick; -Before and after treating a cut or wound; -After using the toilet; -After changing incontinent products or cleaning up after someone who has used the toilet; -After blowing your nose, coughing, or sneezing; -After touching an animal or animal waste; -After handling pet food or pet treats; and -After touching garbage. The Centers for Disease Control and Prevention (CDC) Hand Hygiene in Health Care Settings Healthcare Providers dated January 8, 2021, directed health care workers to wash their hands immediately before touching a patient [resident], after touching a patient or patient's immediate environment, after glove removal, and when hands were visibly soiled. SHARPS On November 29, 2022, at approximately 8:10 a.m., the surveyor observed ULP-G cap a used insulin pen needle and place the needle into their pocket. The licensee's Disposal of Contaminated Materials dated July 20, 2021, indicated staff would not recap needles. The U.S. Food and Drug Administration (FDA) Safely Using Sharps at Home, Work and on Travel, dated November 9, 2021, directed used sharps to be immediately placed into a sharp's container. SHARED MEDICAL EQUIPMENT On November 29, 2022, between 7:07 a.m., and 7:26 a.m., the surveyor observed ULP-F obtain a temperature and blood oxygen level on R11, R12, and R13. The surveyor observed the	0 510		

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0 510	Continued From page 7 thermometer and pulse oximeter were not disinfected before or after use of R11, R12, and R13. On November 29, 2022, at approximately 8:12 a.m., the surveyor observed ULP-G use a house stock blood glucose machine on R4. ULP-G did not disinfect the blood glucose machine before or after use. On November 29, 2022, at approximately 11:38 a.m., the surveyor observed ULP-G use a house stock blood glucose machine on R10. ULP-G did not disinfect the blood glucose machine before or after use. On November 30, 2022, at 9:38 a.m., RN-A stated staff were expected to clean shared equipment with a disinfectant between each resident. The licensee's Cleaning of Shared Medical Equipment dated July 20, 2021, indicated shared medical equipment would be cleaned routinely and disinfected before and after use. The CDC Disinfection of Healthcare Equipment dated May 24, 2019, indicated it is a requirement to clean equipment with appropriate disinfectant after contact with a blood or other potentially infectious materials. In addition, medical equipment surfaces should be disinfected with an environmental protection agency (EPA) registered low or intermediate level disinfectant. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		

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0 630	Continued From page 8	0 630		
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for one of three residents (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to 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: R4 admitted to the licensee for services on July 14, 2022.	0 630		

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0 630	Continued From page 9 R4's diagnoses included hypertension, chronic kidney disease, and diabetes mellitus type 2. R4's Service Agreement signed September 1, 2022, indicated R4 received assistance with housekeeping, activities, safety checks, laundry, meals, medication management, diabetic management, dressing, grooming, toileting, bathing, and skin care. R4's Assessment for Client Vulnerability, Safety and Risk to Others dated July 14, 2022, indicated R4 was not at risk to abuse others however, lacked an IAPP to include: - person's susceptibility to abuse by another individual, including other vulnerable adults; and - statements of the specific measures to be taken to minimize the risk of abuse to that person. On November 30, 2022, at 9:40 a.m., registered nurse (RN)-A stated the licensee updated their IAPP a month ago to be in accordance with the assisted living statues. In addition, RN-A stated they were updating the resident's IAPP when the resident's 90-day assessment was due because it was "overwhelming" to complete the new IAPP on all residents in the facility at once. The licensee's Individual Abuse Prevention Plans policy dated July 20, 2021, indicated the IAPP would include an individualized review or assessment of the person's susceptibility to abuse by other individuals or other vulnerable adults and would include statements of specific measures to be taken to minimize the risk of abuse to that person. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	0 630		

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0 630	Continued From page 10 days	0 630		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to have a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all residents receiving services under the assisted	0 680		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUITE LIVING SR CARE OF BP	8500 REGENT AVENUE NORTH BROOKLYN PARK, MN 55443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 680	Continued From page 11 living license. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's emergency disaster preparedness plan lacked evidence of the following required content: - emergency prep testing requirements. On November 28, 2022, regional director of operations (RDO)-C stated the licensee recently developed elopement and tornado drill forms however, drills had not been implemented. The licensee's Emergency Preparedness Plan - Appendix Z Compliance dated July 20, 2021, indicated the licensee would conduct at minimum, two emergency preparedness drills every 12 months that excluded the required fire and evacuation drills. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the	0 730		

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0 730	Continued From page 12 following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution;	0 730		

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0 730	Continued From page 13 (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record included a discharge summary for one of two discharged residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1 admitted for services on December 29, 2021, and discharged on August 1, 2022. R1's diagnosis included brief psychotic disorder. R1's record lacked a discharge summary. On November 28, 2022, at approximately 1:25 p.m., registered nurse (RN)-A stated, "I'm going to be very honest. I don't have a discharge summary." The licensee's Resident Record - Information and Content policy dated July 19, 2021, indicated	0 730		

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0 730	Continued From page 14 resident records would include a discharge summary. No further information provided. TIME PERIOD OF CORRECTION: Twenty-one (21) days	0 730		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, 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).	0 800		

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0 800	Continued From page 15 Findings include: On a facility tour on December 1, 2022, at approximately 11:15 p.m. with Housing Director (HD)-D, it was observed that the exterior exit path leading through the gated area from the marked exit doors located in the dining room and corridor, were not maintained clear of ice and snow. Keeping this exterior exit path and the exterior door landings clear of ice and snow helps provide unobstructed exiting for occupants and access for emergency responders in the event of an emergency. This deficient condition was visually verified by HD-D accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (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	0 810		

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0 810	Continued From page 16 receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on a record review and interview, the licensee failed to develop a fire safety and evacuation plan with required elements, failed to provide required employee and resident training on fire safety and evacuation, and failed to conduct the required evacuation drills. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). A record review and interview was conducted on	0 810		

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0 810	Continued From page 17 December 1, 2022, at approximately 12:15 p.m. of documents provided by Housing Director (HD)-D on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Findings include: Record review of the available documentation indicated that the licensee did not maintain the fire safety and evacuation plan for the facility. The fire safety and evacuation plan was vague and did not contain procedures specific to the facility. Record review of the available documentation indicated that the licensee did not have specific employee actions to be taken in the event of a fire or similar emergency. Record review of the available documentation indicated that the licensee did not have fire protection procedures necessary for residents included in the fire safety and evacuation plan. Record review of the available documentation indicated that the fire safety and evacuation plan did not include 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. Record review of the available documentation indicated that employees did not receive training upon initial hire and twice per year thereafter on the facility fire safety and evacuation plan. Record review of the available documentation indicated that the licensee did not provide training to residents who are capable of self-evacuation	0 810		

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0 810	Continued From page 18 on the proper actions to be taken in the event of a fire in regard to movement, evacuation, and relocation. Record review of the available documentation did not indicate that evacuation drills had been conducted twice per year per shift and least once every other month as required. All deficiencies were verified by HD-D during the interview at approximately 12:15 p.m. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 940 SS=C	144G.50 Subd. 2 (e; 5-7) Contract information (5) a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: (i) whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; (ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); (iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; (iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; (v) a statement that medical assistance waivers	0 940		

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0 940	Continued From page 19 provide payment for services, but do not cover the cost of rent; (vi) a statement that residents may be eligible for assistance with rent through the housing support program; and (vii) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; (6) the contact information to obtain long-term care consulting services under section 256B.0911; and (7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written assisted living contract with all required content. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On November 28, 2022, housing director (HD)-D provided the surveyor with a blank Residency Agreement and indicated the document was used by licensee for all residents who received services. The Residency Agreement lacked the licensee's information on the following content: - a description of the facility's policies related to	0 940		

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0 940	Continued From page 20 medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: - whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; - a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; - a statement that residents may be eligible for assistance with rent through the housing support program; and - a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program. On November 30, 2022, at 11:45 a.m., HD-D stated the licensee participated in medical assistance waivers and the housing support program. HD-D stated the licensee had limits for who could receive customized living services or participate in the housing support program. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 940		
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	01500		

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01500	Continued From page 21 provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this 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	01500		

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01500	Continued From page 22 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 interview and record review, the licensee failed to ensure an employee received at least eight hours of annual training for each 12 months of employment for one of three employees (registered nurse (RN)-A). 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: RN-A had a hire date of October 21, 2020, to provide supervision and oversite to unlicensed personnel and provide direct services residents under the comprehensive license. RN-A began providing assisted living services on August 1, 2021. RN-A's record included 5.25 hours of annual training however, lacked evidence of at least	01500		

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01500	Continued From page 23 eight hours of annual training to include: - training on reporting of maltreatment of vulnerable adults under section 626.557; - review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; - review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. On November 30, 2022, at 9:46 a.m., registered nurse (RN)-A stated the licensee completed education through EduCare (a training software program) and at in person meetings. In addition, RN-A stated the licensee lacked documentation of some of the trainings. The licensee's Annual Required Staff Training policy dated July 20, 2021, indicated all staff that performed direct care services would complete at least eight hours of annual training for each 12 months of employment. In addition, the content listed above must be included in the training every 12 months to all staff who perform direct care services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One	01500		

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01500	Continued From page 24 (21) days	01500		
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions.	01730		

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01730	Continued From page 25 (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 record with the required content for one of three residents (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to 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: R4 admitted to the licensee for services on July 14, 2022. R4's diagnoses included hypertension, chronic kidney disease, and diabetes mellitus type 2. R4's Service Agreement signed September 1, 2022, indicated R4 received assistance with housekeeping, activities, safety checks, laundry, meals, medication management, diabetic management, dressing, grooming, toileting, bathing, and skin care.	01730		

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01730	Continued From page 26 R4's electronic medication administration record (EMAR) dated November 1, 2022, through November 30, 2022, included ascorbic acid 500 milligrams (mg), calcium-magnesium-zinc-D3 one tablet, ergocalciferol capsule 50,000 units (U), furosemide 20 mg, glipizide extended release (ER) 2.5 mg, glucosamine 750 mg, Lantus 11 to 16 U, melatonin 3 mg, pantoprazole 20 mg, spironolactone 50 mg, ursodiol 600 mg, Systane Gel 0.4 - 0.3 percent (%), cephalexin 500 mg, NovoLog 5 U, and lactulose 10 gram (g)/15 milliliter (ml). On November 29, 2022, at 8:02 a.m., the surveyor observed unlicensed personnel (ULP)-G administer oral medications to R4. R4's Assessment of Need for Medication Reminders, Assistance, Administration or Central Storage dated July 14, 2022, and Individualized Medication Management Plan dated September 1, 2022, included parts of the individualized medication management plan. The individualized medication management plan lacked the following: - documentation of specific resident instructions relating to the administration of medications; - person responsible for monitoring medication supplies and refills; - identification of medication management tasks that may be delegated to unlicensed personnel; and - any resident-specific requirements. On November 30, 2022, at 10:07 a.m., registered nurse (RN)-A stated the licensee updated their individualized medication management plan a month and a half ago to include the required content listed above. In addition, RN-A stated	01730		

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01730	Continued From page 27 they were in the process of updating medication management plans with resident's quarterly reviews. The licensee's Medication Management Individualized Plan policy dated July 2021, indicated the licensee would develop and maintain a current individualized medication management record for each resident based on resident's assessment that would contain the content listed above. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01750 SS=I	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure prior to delegating the task of medication administration, the unlicensed personnel (ULP) were trained in	01750	On December 21, 2022, the immediacy of correction order 1750 was removed, however, non-compliance remained at a level 3, scope of widespread violation.	

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01750	Continued From page 28	01750		

the proper methods to perform the task or procedure for each resident and were able to demonstrate, to the registered nurse (RN), the ability to competently follow the procedure for one of one employee (unlicensed personnel (ULP)-G).

This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).

The findings include:

ULP-G was hired on September 7, 2022.

On November 29, 2022, at 8:10 a.m., the surveyor observed ULP-G administer five units of NovoLog to R4. ULP-G completed blood glucose monitoring after insulin administration to R4.

ULP-G's employee record included a competency evaluation titled Insulin Pens dated September 19, 2022, and indicated licensed practical nurse (LPN)-E evaluated ULP-G's competency on insulin administration. Underneath LPN-E's signature and date on the competency form was an undated ink stamp of RN-A's signature.

On December 20, 2022, at 10:09 a.m., ULP-G stated they were trained for insulin administration by seasoned ULP's, and the LPN completed the competency check.

On December 20, 2022, at 10:11 a.m., LPN-E stated they completed competencies including

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01750	Continued From page 29 insulin administration for ULP's and used a competency packet provided by the director of nursing to complete the competency accurately. On December 20, 2022, at 10:12 a.m., RN-A stated they complete training and competencies with the LPN and once the LPN was found competent in the task, they train and complete competency packets with the ULP's. RN-A proceeded to state the LPN and RN both complete competencies with the ULP's however, "in a perfect world it would be me." In addition, RN-A stated the undated ink stamp signature at the bottom of the competency indicated the competencies were completed however, did not indicate they (RN-A) assisted with the competency. The surveyor inquired how a ULP would know to complete a blood glucose prior to administration of insulin. RN-A stated ULP's were trained to administer insulin after blood glucose monitoring occurred. The licensee's Delegation of Assisted Living Services policy dated July 20, 2021, indicated a RN or LPN may delegate tasks only to staff who are competent and possess the knowledge and skills consistent with the complexity of the task according to the appropriate Minnesota practice act. In addition, when a RN or LPN delegates tasks to the ULP, the person will ensure that prior to the delegation the ULP is trained in the proper methods to perform the task or procedures for each resident and is able to demonstrate the ability to competently follow the procedure and perform the tasks. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	01750		

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01890	Continued From page 30	01890		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were maintained bearing an original prescription label and time sensitive medications were dated when opened for one of seven residents (R7). 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: ORIGINAL PRESCRIPTION LABELS On November 29, 2022, at approximately 8:35 a.m., the surveyor observed the assisted living medication cart and observed the following medications with illegible prescription labels: - R7 Biotene DRY MOUTH Moisturizing Spray. On November 30, 2022, at approximately 9:57 a.m., registered nurse (RN)-A stated the	01890		

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01890	Continued From page 31 licensee's expectation was all prescriptions would have legible prescription labels. The licensee's Medication - Prescription Drugs & Prohibition policy dated July 21, 2020, indicated prescription medications would be kept in original container bearing the original prescription label with legible information. TIME SENSITIVE MEDICATIONS On November 29, 2022, at 6:55 a.m., the surveyor observed the medication refrigerator and observed the following time sensitive medications were opened without a date open label: - R7 two bottles of latanoprost .005 percent (%) filled on May 11, 2022, and July 8, 2022. The manufacturer's instructions for the use of Latanoprost Ophthalmic Solution dated September 1, 2021, directed for the eye drop to be discarded 6 weeks after opening. On November 30, 2022, at approximately 11:40 a.m., registered nurse (RN)-A stated time sensitive medications should be dated when opened. The licensee's Medication - Prescription Drugs & Prohibition policy dated July 21, 2020, indicated prescription medications would contain an expiration date or beyond-use date of a time-dated drug. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

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01910	Continued From page 32	01910		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide documentation in the resident's record regarding the disposition of medication to include the medication strength, prescription number, quantity, date of disposition, and names of staff and other individuals involved in the disposition for one of two discharged 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 an isolated scope (when one or a limited number of	01910		

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01910	Continued From page 33 residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1 was discharged from the licensee on August 1, 2022. R1's Order Summary Report active orders dated July 31, 2022, indicated R1 received acetaminophen 325 milligram (mg), amlodipine besylate tablet 10 mg, antacid calcium tablet chewable 500 mg, aripiprazole tablet 10 mg, benztropine mesylate tablet 0.5 mg, Bisacodyl laxative suppository 10 mg, Claritin tablet 10 mg, Depakote sprinkles capsule delayed release sprinkles 125 mg, docusate sodium capsule 100 mg, duloxetine hcl capsule delayed release sprinkle 60 mg, Ferrous Sulfate tablet 325 mg, gabapentin capsule 300 mg, guaifenesin solution 200 mg/10 milliliter (ml), hydrocortisone cream 1 percent (%), hydroxyzine hcl tablet 25 mg, loperamide hcl tablet 2 mg, Melatonin tablet 10 mg, menthol cough drops lozenge, metoprolol succinate ER tablet extended release 24 hour 50 mg, Milk of Magnesia Concentrate Suspension, Nystatin Powder 100000 unit/gram (gm), olanzapine tablet 5 mg, ondansetron tablet disintegrating 8 mg, polyethylene glycol 3350 packet 17 gm, senna-docusate sodium tablet 8.6-50 mg, and triple antibiotic plus ointment 1 %. R1's record lacked a medication disposition to include the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition.	01910		

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01910	Continued From page 34 On November 28, 2022, at approximately 1:25 p.m., registered nurse (RN)-A stated they were unable to locate the medication disposition paperwork for R1. The licensee's Medication Disposal policy dated August 1, 2021, indicated upon discharge from the facility, the licensee would document in the resident's record the disposition of medication including the content listed above. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
01940 SS=F	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy	01940		

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01940	Continued From page 35 services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop a treatment management plan to include all required content for four of four residents (R4, R5, R8 and R9). 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: R4 R4's Service Agreement signed September 1, 2022, indicated R4 received assistance with housekeeping, activities, safety checks, laundry, meals, medication management, diabetic management, dressing, grooming, toileting, bathing, compression therapy, and skin care. R4's Order Summary Report dated November 29, 2022, included blood glucose monitoring before	01940		

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01940	Continued From page 36 meals, and compression stockings on in the morning, off at bedtime. On November 29, 2022, at 8:10 a.m., the surveyor observed ULP-G administer five units (U) of NovoLog to R4. ULP-G completed blood glucose monitoring after insulin administration to R4. R4's treatment plan lacked the following required content for compression therapy and blood glucose monitoring: - specific resident instructions relating to the administration of the treatment; and - procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services and specific resident instructions relating to the administration of the treatment. R5 R5's Service Agreement signed October 18, 2022, indicated R5 received assistance with activities, safety checks, meals, laundry, medication management, diabetic management, oral care, toileting, and wound care. R5's Order Summary Report dated November 29, 2022, included blood glucose monitoring two times per day. R5's treatment plan lacked the following required content for blood glucose monitoring: - specific resident instructions relating to the administration of the treatment. R8 R8's Service Agreement signed August 5, 2022, indicated R8 received assistance with housekeeping, activities, safety checks, laundry,	01940		

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01940	Continued From page 37 meals, medication administration, diabetic management, grooming, toileting, bathing, ambulation, transfers, and wound care. R8's Order Summary Report dated November 30, 2022, included blood glucose monitoring four times per day. R8's treatment plan lacked the following required content for blood glucose monitoring: - specific resident instructions relating to the administration of the treatment. R9 R9's Service Agreement signed October 10, 2022, indicated R9 received assistance with housekeeping, activities, safety checks, laundry, meals, medication administration, diabetic management, oxygen, and skin care. R9's Order Summary Report dated November 30, 2022, included blood glucose monitoring two times per day and placement of continuous positive airway pressure (CPAP) at night. R9's treatment plan lacked the following required content for CPAP therapy and blood glucose monitoring: - specific resident instructions relating to the administration of the treatment. On November 30, 2022, at 10:15 registered nurse (RN)-A stated parameters for blood glucose monitoring would be found in the resident record. The licensee's Treatment & Therapy Management Plan dated July 2021, indicated the licensee would develop and maintain a current individualized treatment and therapy management record for each resident which	01940		

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01940	Continued From page 38 would contain the content listed above. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01950 SS=F	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure prior to delegating nursing tasks of treatment administration, the unlicensed personnel (ULP) were trained in the proper methods to perform the	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36600	A. BUILDING: _____ B. WING _____	12/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUITE LIVING SR CARE OF BP	8500 REGENT AVENUE NORTH BROOKLYN PARK, MN 55443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01950	Continued From page 39	01950		

task or procedure for each resident, and were able to demonstrate, to the registered nurse (RN), the ability to competently follow the procedure for one of one employee (unlicensed personnel (ULP)-G).

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).

The findings include:

ULP-G was hired on September 7, 2022.

On November 29, 2022, at 8:10 a.m., the surveyor observed ULP-G administer five units of NovoLog to R4. ULP-G completed blood glucose monitoring after insulin administration to R4.

ULP-G's employee record included a competency evaluation titled Blood Glucose Testing dated September 19, 2022, and indicated licensed practical nurse (LPN)-E evaluated ULP-G's competency. Underneath LPN-E's signature and date on the competency form was an undated ink stamp of RN-A's signature.

On December 20, 2022, at 10:09 a.m., ULP-G stated they were trained for blood glucose monitoring by seasoned ULP's, and the LPN completed the competency check.

On December 20, 2022, at 10:11 a.m., LPN-E stated they completed competencies including blood glucose monitoring for ULP's and used a

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	36600	A. BUILDING: _____ B. WING _____	12/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUITE LIVING SR CARE OF BP	8500 REGENT AVENUE NORTH BROOKLYN PARK, MN 55443

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01950	Continued From page 40 competency packet provided by the director of nursing to complete the competencies accurately. On December 20, 2022, at 10:12 a.m., RN-A stated they complete training and competencies with the LPN and once the LPN was found competent in the task, they train and complete competency packets with the ULP's. RN-A proceeded to state the LPN and RN both complete competencies with the ULP's however, "in a perfect world it would be me." In addition, RN-A stated the undated ink stamp signature at the bottom of the competency indicated the competencies were completed however, did not indicate they assisted with the competency. The surveyor inquired how a ULP would know to complete a blood glucose prior to administration of insulin. RN-A stated ULP's were trained to administer insulin after blood glucose monitoring occurred. The licensee's Delegation of Assisted Living Services policy dated July 20, 2021, indicated a RN or LPN may delegate tasks only to staff who are competent and possess the knowledge and skills consistent with the complexity of the task according to the appropriate Minnesota practice act. In addition, when a RN or LPN delegates tasks to the ULP, the person will ensure that prior to the delegation the ULP is trained in the proper methods to perform the task or procedures for each resident and is able to demonstrate the ability to competently follow the procedure and perform the tasks. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		

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	36600	A. BUILDING: _____ B. WING _____	12/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUITE LIVING SR CARE OF BP	8500 REGENT AVENUE NORTH BROOKLYN PARK, MN 55443

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01960	Continued From page 41	01960		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure blood glucose monitoring was administered to comply with accepted health care, medical, and nursing standards for one of one resident (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R4 admitted to the licensee for services on July 14, 2022. R4's diagnoses included hypertension, chronic	01960		

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	36600	A. BUILDING: _____ B. WING _____	12/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUITE LIVING SR CARE OF BP	8500 REGENT AVENUE NORTH BROOKLYN PARK, MN 55443

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01960	Continued From page 42 kidney disease, and diabetes mellitus type 2. R4's Service Agreement signed September 1, 2022, indicated R4 received assistance with housekeeping, activities, safety checks, laundry, meals, medication management, diabetic management per electronic medication administration record (EMAR), dressing, grooming, toileting, bathing, and skin care. R4's EMAR dated November 1, 2022, through November 30, 2022, included blood sugar before meals. The order lacked specific instructions and when to notify a licensed health care professional related to blood glucose monitoring. On November 29, 2022, at 8:10 a.m., the surveyor observed ULP-G complete blood glucose monitoring after administration of insulin to R4. On November 30, 2022, at 10:15 a.m. registered nurse (RN)-A verified R4's record lacked parameters and when to notify a licensed health professional. RN-A stated parameters on blood glucose monitoring should be found on the EMAR. On December 20, 2022, at 10:16 a.m., RN-A stated blood glucose monitoring should be conducted prior to insulin administration and the ULP's received this information when they completed their competency on blood glucose monitoring. The Mayo Clinic Blood Sugar Testing: Why, When and How dated February 1, 2022, indicated blood glucose monitoring is recommended before use of an intermediate or long-acting insulin to provide information on blood sugar levels,	01960		

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	36600	A. BUILDING: _____ B. WING _____	12/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUITE LIVING SR CARE OF BP	8500 REGENT AVENUE NORTH BROOKLYN PARK, MN 55443

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01960	Continued From page 43 monitor the effect of diabetic medication, and to track treatment goals. The licensee's Blood Sugar Testing- Shared Equipment Use dated July 2021, indicated to follow the manufacturer's instructions for proper use of the specific glucometer being used, document the results of the reading and notify the RN of any unusual results. The policy lacked instructions for when to complete a blood glucose monitoring. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide hazard vulnerability assessment or safety risk assessment of the physical environment on and around the property	02040		

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	36600	A. BUILDING: _____ B. WING _____	12/01/2022

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02040	Continued From page 44 for the facility. This deficient practice had the ability to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A record review and interview were conducted December 1, 2022, at approximately 12:15 p.m. with Housing Director (HD)-D on the hazard vulnerability assessment for the physical environment of the facility. During interview, HD-D provided documentation the hazard vulnerability assessment was performed on and around the property but was not able to provide documentation or locate the mitigation factors at the time of survey. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		

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

Type: Full
Date: *11/29/22*
Time: 13:00:00
Report: 1013221381

Food and Beverage Establishment Inspection Report

Location:
Suite Living Sr Care Of Bp
8500 Regent Avenue North
Brooklyn Park, MN55443
Hennepin County, 27

Establishment Info:
ID #: 0037588
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6517702273
ID #:

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

The following orders were issued during this inspection.

3-500B Microbial Control: hot and cold holding

3-501.16A2 ** Priority 1 **

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

WHIPPED BUTTER WAS STORED AT ROOM TEMPERATURE IN THE KITCHEN PREP AREA. PER STAFF THE FOOD WAS REMOVED FROM TEMP CONTROL 3 HRS PRIOR. COMPLY WITH ABOVE RULE. DISCUSSED TEMP CONTROL FOR TCS FOODS AND THE WHIPPED BUTTER WAS MOVED TO A REFRIGERATOR.

Corrected on Site

3-500C Microbial Control: date marking

3-501.17B ** Priority 2 **

MN Rule 4626.0400B Mark the refrigerated, ready-to-eat, TCS food prepared and packaged in a processing plant and opened and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded. The date must not exceed the manufacturer's use-by-date.

AN OPEN CONTAINER OF READY-TO-EAT SLICED CANTALOUPE AND MELON WITHOUT A DATE WAS LOCATED IN THE PREP AREA TALL COOLER. PER STAFF THE FOOD CONTAINER WAS OPENED ON 11/26. COMPLY WITH ABOVE RULE. DISCUSSED DATE MARKING AND STAFF DATE MARKED THE FOOD.

Corrected on Site

6-300 Physical Facility Numbers and Capacities

6-301.11 ** Priority 2 **

MN Rule 4626.1440 Provide an adequate supply of hand soap at each handwashing sink or group of 2 adjacent handwashing sinks.

SOAP DISPENSER WAS EMPTY LOCATED AT THE BACK PREP AREA HAND WASHING SINK. STAFF IDENTIFIED THE SINK AS A HAND WASHING SINK. COMPLY WITH ABOVE RULE. STAFF STOCKED SOAP AT THE SINK.

Corrected on Site

Surface and Equipment Sanitizers

Quaternary Ammonia: = 400 ppm at Degrees Fahrenheit
Location: Sanitizer - prep area
Violation Issued: No

Hot Water: = at 164 Degrees Fahrenheit
Location: Dish machine
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cake
Temperature: 4 Degrees Fahrenheit - Location: Freezer 1
Violation Issued: No

Process/Item: Sliced melon
Temperature: 40 Degrees Fahrenheit - Location: Cooler 1
Violation Issued: No

Process/Item: Chopped lettuce
Temperature: 40 Degrees Fahrenheit - Location: Cooler 1
Violation Issued: No

Process/Item: Chicken
Temperature: 10 Degrees Fahrenheit - Location: Freezer 2
Violation Issued: No

Process/Item: Goulash
Temperature: 39 Degrees Fahrenheit - Location: Cooler 2
Violation Issued: No

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

Discussed serving highly susceptible populations, illness policy, cleaning, ware washing, produce washing, final cook temperatures, temperature control, date marking, sanitizer use, and food handling procedures.

Food and Beverage Establishment Inspection Report

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 1013221381 of 11/29/22.

Certified Food Protection Manager: Marcus Howze

Certification Number: 104744 Expires: 11/20/23

Inspection report reviewed with person in charge and emailed.

Signed: _____

Marcus Howze
Head Cook

Signed: JM

Jerry Malloy
Public Health Sanitarian
FPLS Metro
651-201-3998
jerry.malloy@state.mn.us