DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

November 21, 2023

Licensee
Amira Choice Plymouth
18405 Old Rockford Road
Plymouth, MN 55446

RE: Project Number(s) SL33599015

Dear Licensee:

On November 20, 2023, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the July 27, 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,

Casey DeVries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290

PMB

Electronically Delivered

November 2, 2023

Licensee
Amira Choice Plymouth
18405 Old Rockford Road
Plymouth, MN 55446

RE: Project Number(s) SL33599015

Dear Licensee:

On October 17, 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 July 27, 2023. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the July 27, 2023 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on July 27, 2023, found not corrected at the time of the October 17, 2023, follow-up survey and/or subject to penalty assessment are as follows:

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

The details of the violations noted at the time of this follow-up survey completed on October 17, 2023 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,000,00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

IMPOSITION OF FINES:

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

§144G.20.

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

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

Please address your cover letter for reconsideration requests to:

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

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the MDH within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. Requests for hearing may be emailed to: **Health.HRD.Appeals@state.mn.us**.

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

We urge you to review these orders carefully. If you have questions, please contact Casey DeVries at 651-201-5917.

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,

Casey DeVries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33599	A. BUILDING: _____ B. WING _____	R 10/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMIRA CHOICE PLYMOUTH	18405 OLD ROCKFORD ROAD PLYMOUTH, MN 55446

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL33599015-1 On October 16, 2023, through October 17, 2023, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on July 27, 2023. At the time of the survey, there were 97 active residents; 59 of whom received services under the Assisted Living with Dementia Care license. As a result of the revisit, the following orders were reissued.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	{0 480}		

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{0 480}	Continued From page 1 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: No further action required.	{0 480}		
{0 510} SS=D	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: No further action required.	{0 510}		
{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;	{0 810}		

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{0 810}	Continued From page 2 (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: No further action required.	{0 810}		
{01620} SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the	{01620}		

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{01620}	Continued From page 3 resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: No further action required.	{01620}		
{01640} SS=E	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	{01640}		

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{01640}	Continued From page 4 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: No further action required.	{01640}		
{01730} SS=D	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	{01730}		

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{01730}	Continued From page 5 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. (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: No further action required.	{01730}		
{01760} SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not	{01760}		

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{01760}	Continued From page 6 administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: No further action required.	{01760}		
{01880} SS=D	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: No further action required.	{01880}		
{01890} SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: No further action required.	{01890}		
{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	{02040}		

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{02040}	Continued From page 7 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: No further action required.	{02040}		
{02310} SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical or nursing standards for four of six residents (R16, R17, R18, R19) with hospital and consumer bed rails and assistive devices. 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	{02310}		

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{02310}	Continued From page 8 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: R16 R16 had a diagnosis of hyperlipidemia (high cholesterol). R16 admitted to the licensee on March 24, 2023, and began receiving assisted living services. R16's Service Plan Agreement dated April 13, 2023, indicated R16 received assistance with meal set up, monthly vital signs, bed making, housekeeping, eye drop administration, and safety checks. On October 16, 2023, at 12:42 p.m., the surveyor received a picture via email correspondence from the licensee of a halo bed rail on R16's bed. On October 16, 2023, at 10:38 a.m., 12:38p.m., 1:36 p.m., and 2:22 p.m., the surveyor requested R16's risk and benefit education and documentation for bed rails. On October 16, 2023, at 3:02 p.m., the surveyor received R16's risk and benefit for bed rails which indicated R16's family member chose to use bed rails after they received a risk and benefit discussion via phone on October 16, 2023, at 2:54 p.m., during the survey. R16's record lacked a risk vs. benefits discussion (individualized to each resident's risks) completed prior to the start of the survey. R17	{02310}		

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{02310}	Continued From page 9 R17 had a diagnosis of fracture of neck of right femur. R17 admitted to the licensee on October 8, 2019, under the licensee's former comprehensive license and began receiving assisted living services on August 1, 2021. R17's Service Plan Agreement signed June 20, 2023, indicated R17 received assistance with bathing, dressing, monthly vital signs, bed making, housekeeping, laundry, medication administration, warfarin management, transfers, toileting, and face to face safety checks with direction to staff to report to nurse if unable to locate R17. R17's service check off dated September 16, 2023, through October 16, 2023, included a safety check performed at 11:45 a.m., and 5:00 p.m., daily. R17's 90-day assessment titled Basic Assessment / ULP Services completed on August 31, 2023, indicated R17 had a hospital bed with medical half-length T-style bed rails, Zone 4 was greater than 2 3/8 inches, and the bed rails did not meet the Food and Drug Administration (FDA) requirements. In addition, the assessment indicated the device was not appropriate for resident use and "Remove bed rail and discuss further interventions and options with resident or representative: Recommending use of alternative device." R17's record lacked any necessary information related to interventions to mitigate safety risk or negotiated risk agreements. On October 16, 2023, at 1:17 p.m., clinical nurse	{02310}		

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{02310}	Continued From page 10 supervisor (CNS)-C stated R17's bed rails did not meet the FDA requirements. The surveyor inquired what interventions were put into place once the licensee discovered R17's bed rails did not meet the FDA requirements. CNS-C stated they held a discussion to discuss alternative bed rail options, completed 90-day assessments which included a bed rail assessment, and inspected bed rails to ensure they were installed appropriately. The surveyor inquired if there were other interventions put into place to mitigate the safety risk. CNS-C stated, "[R17] has full services, transfers, mobility, not a whole heck of a lot for interventions we could do for her." On October 17, 2023, at 10:00 a.m., unlicensed personnel (ULP)-N stated when they completed safety checks on R17 they made sure R17 did not have a fall. On October 17, 2023, at 10:04 a.m., the surveyor observed a hospital bed with bilateral half rails on R17's bed. R17 stated they used the bed rail to "help get up." R18 R18 had a diagnosis of coronary artery disease. R18 admitted to the licensee on January 11, 2019, under the licensee's former comprehensive license and began receiving assisted living services on August 1, 2021. R18's Service Plan Agreement signed August 28, 2023, indicated R18 received assistance with compression therapy, bathing, nail care, monthly vital signs, housekeeping as requested, trash removal, laundry, medication administration, escorts, and face to face safety checks with direction to staff to report to nurse if unable to	{02310}		

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{02310}	Continued From page 11 locate R18. R18's service check off dated September 16, 2023, through October 16, 2023, included a safety check performed at 11:30 a.m., daily. R18's progress note dated July 25, 2023, indicated R18's consumer bed rails were recalled, R18's family was notified and educated on the risk and benefits of current consumer rails, and were provided examples of alternative devices. In addition, R18's family member was in agreement to replace current device and facility would follow up with family member in one week. R18's progress note dated July 28, 2023, indicated bed rails were discussed with family however, new bed rails were not ordered. R18's 90-day assessment titled Basic Assessment /ULP Services completed July 28, 2023, indicated R18 had an endurance hand bed rail that was recalled and R18's family was made aware of recall and other alternative devices that could be used. R18's 90-day assessment titled Basic Assessment/ ULP Services completed during the survey, on October 16, 2023, indicated R18 had an AOHHL bed rail. On October 17, 2023, at 10:09 a.m., ULP-N stated when they completed safety checks on R18 they ensure R18 was dressed appropriately and offered toileting. On October 17, 2023, at 10:13 a.m., the surveyor observed a consumer bed rail with AOHHL written on the bed rail, located on the right-hand side bed attached to the box spring with a black strap.	{02310}		

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	33599	A. BUILDING: _____ B. WING _____	R 10/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{02310}	Continued From page 12 R18's record lacked: - installation and use according to manufacturer's guidelines; and - any necessary information related to interventions to mitigate safety risk or negotiated risk agreements. R19 R19 had a diagnosis of dysarthria (slurred speech) following a cerebral infarction (stroke). R19 admitted to the licensee on January 11, 2023, and began receiving assisted living services. R19's Service Plan Agreement signed February 28, 2023, indicated R19 received assistance with activities, bathing, meal set up, dressing, grooming, oral care, monthly vital signs, housekeeping, laundry, medication administration, bed mobility, escorts, transfers, safety checks, behavior management, and toileting. On October 16, 2023, at 12:42p.m., the surveyor received a picture via email correspondence from the licensee of a universal assist bar on R19's bed. On October 16, 2023, at 10:38 a.m., 12:38p.m., 1:36 p.m., and 2:22 p.m., the surveyor requested R19's risk and benefit for bed rails. On October 16, at 3:02 p.m., the surveyor received R19's risk and benefit for bed rails which indicated R19's family member chose to use the bed rail after they received a risk and benefit discussion via phone on October 16, 2023, at 2:50 p.m., completed during the survey.	{02310}		

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{02310}	Continued From page 13 R19 record lack risk vs. benefits discussion (individualized to each resident's risks) completed prior to the start of the survey. On October 17, 2023, at 10:21 a.m., ULP-M stated when they complete safety checks they check to see if a resident is "ok or on the floor" and they complete what is written on the care plan. October 17, 2023, at 10:22 a.m., ULP-E stated when they complete safety checks they "make sure they are breathing, in good condition, and responding." On October 17, 2023, at 10:46 a.m., the surveyor inquired what was the expectation of the licensee for safety checks. CNS-C stated ULP were to "lay eyes" on the person to ensure they were breathing, "ok", and were located in the facility. The surveyor inquired how ULP were trained on conducting safety checks. CNS-C stated they were trained onsite and were trained to follow up with nursing if they were unable to locate a resident. CNS-C stated the service task said something similar to the training to contact a nurse. The surveyor inquired why R16 and R19's risk and benefit for bed rails was completed during survey. CNS-C stated the licensee conducted a bed rail audit after the last Minnesota Department of Health (MDH) survey however, R16 and R19's names were not on the audit list. CNS-C stated they were unaware of why R16 and R19's name were not on the audit list to review required documents needed when bed rails were used. The surveyor inquired if interventions to mitigate the safety risk were added after the licensee knew R17's bed rails did not meet FDA standards. CNS-C stated they did	{02310}		

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{02310}	Continued From page 14 not add interventions to the care plan or service plan specifically related to bedrails to mitigate the safety risk after they discovered R17's bed rails did not meet FDA requirements. In addition, CNS-C stated R18's consumer bed rails were recalled. CNS-C stated they discussed alternative bed rail options with R18's family and R18's family said they would look into alternative options. CNS-C stated they followed up on the discussion with R18's family member days later without resolution. On October 16, 2023, CNS-C stated they went to R18's room and noticed a different consumer bed rail in place, they took a picture, attempted to obtain manufacture's installation instructions on the consumer bed rails, and completed a change of condition reassessment on R18. In addition, CNS-C stated they were unable to find clear manufacture installation instruction for bed rails in place on October 16, 2023. The FDA document titled Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities, and Home Care Settings dated April 2003, recommended the decision to utilize or remove bed rails should occur within the framework of an individual resident assessment and should be documented clearly and approved by the interdisciplinary team. The resident chart should include a risk-benefit assessment that identifies why other interventions are not appropriate or effective. The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently Asked Questions (FAQs) dated August 7, 2023, indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and	{02310}		

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{02310}	Continued From page 15 physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." The MDH website indicated for consumer bed rails, the licensee must include in their documentation: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Installation and use according to manufacturer's guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". The licensee's Assessment and Use of Side Rails dated February 1, 2023, indicated the nurse would educate the resident or resident representative about the risks related to bed rails. In addition, manufactures information must be available to the facility and the device must be installed and maintained per manufacturers guidelines and must meet FDA measurement requirements. If the nurse determined the bed rails were not an appropriate device for the resident, the device would be removed, and the resident or resident representative would be	{02310}		

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{02310}	Continued From page 16 provided with options and alternative needs for addressing the resident needs which included: - recommendation of alternative bed rail or transfer bar that meets FDA standards; - alternative products; and - changes to the service plan. The nurse would document these conversations and recommendations in the resident record.	{02310}		

Electronically Delivered

August 10, 2023

Licensee
Amira Choice Plymouth
18405 Old Rockford Road
Plymouth, MN 55446

RE: Project Number(s) SL33599015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 27, 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 . . ."

IMPOSITION OF FINES

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

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

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5), the MDH may impose fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment.
The MDH may impose 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 MDH

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 (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 survey:

St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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

Please address your cover letter for reconsideration requests to:

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

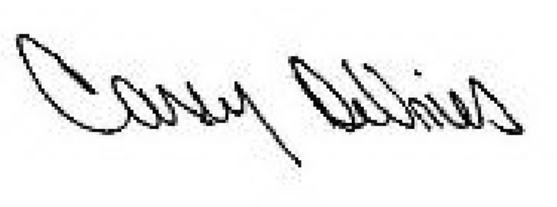
REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the MDH within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. Requests for hearing may be emailed to: **Health.HRD.Appeals@state.mn.us**.

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

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,



Casey DeVries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 Fax: 651-281-9796

JMD

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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: SL33599015-0 On July 24, 2023, through July 27, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 91 active residents; 58 of whom were receiving services under the Assisted Living with Dementia Care license. An immediate correction order was identified on July 25, 2023, issued for SL33599015-0, tag identification 2310. On July 26, 2023, the immediacy of correction order 2310 was removed, however non-compliance remained at a level three, widespread violation.	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 License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (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 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 July 24, 2023. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=D	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	0 510		

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0 510	Continued From page 2 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 that complied with accepted health care, medical, and nursing standards for infection control related to gloving and hand hygiene for two of five unlicensed personnel ((ULP)-F, ULP-G). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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-G ULP-G was hired on June 7, 2022, to provide direct cares and services to residents. On July 25, 2023, at 7:24 a.m. to 7:57 a.m., during continuous observation, the surveyor observed ULP-G wash hands, apply gloves, gather items for morning cares, apply socks and pants up to thigh area on R8, move mechanical	0 510		

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0 510	Continued From page 3 stand next to bed, assist R8 to a sitting position at the end of the bed, attach sling to mechanical stand, transferred R8 from the bed to the bathroom, and removed R8's soiled incontinent brief. Without glove removal or performing hand hygiene, ULP-G lowered R8 onto the toilet, made R8's bed, tidied R8's room, answered cell phone, exited R8's room into the hallway, then removed gloves across the hallway. Without performing hand hygiene, ULP-G went into two supply rooms to look for wipes and re-entered R8's room. Without performing hand hygiene, ULP-G applied a new pair of gloves, stood R8, and performed perineal care. Without glove removal or performing hand hygiene, ULP-G applied new incontinent brief, transferred R8 to from the toilet to the wheelchair with use of stand lift, removed stand lift sling, removed R8's night gown, applied deodorant to R8's underarms, dressed upper body, assisted with wheelchair mobility to the bathroom, set up R8's oral cares, removed gloves, and performed hand hygiene. On July 25, 2023, at 9:28 a.m., ULP-G stated they were trained on infection control through EduCare (a training software) and during daily "standup" meetings. In addition, ULP-G stated they were trained to not wear gloves in the hallway, to wash hands before glove application, and wash hands after removal. The surveyor inquired why hand hygiene was not performed after glove removal in resident's room. ULP-G stated their routine was to wash their hands in the room down the hallway however, that was occupied by the family of a resident who passed away because of this, it changed their normal routine. ULP-E ULP-E was hired on August 1, 2013, to provide	0 510		

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0 510	Continued From page 4 direct cares and services to residents. On July 25, 2023, at 7:39 a.m., the surveyor observed ULP-E without performing hand hygiene apply clean gloves, and administer eyedrops to R13. ULP-E then began administering oral medications to R13. During the administration of medications, the surveyor observed ULP-E drop a pill onto the floor. ULP-E then quickly picked up the medication off the floor and place the pill back into the medication cup to administer to R13. Without removing gloves or performing hand hygiene, ULP-E administered a second set of eye drops to R13. ULP-E then removed gloves and left the room. The surveyor observed ULP-E perform hand hygiene at a sink in facility gathering room. On July 25, 2023, at 7:51 a.m., the surveyor observed ULP-E enter the room of R15 to provide morning cares. ULP-E assisted R15 out of bed and into the bathroom. The surveyor observed ULP-E assist with the removal of incontinence products without hand hygiene or applying clean gloves. While R15 was on the toilet, ULP-E tidied R15's bed sheets. After completing tidying of room, without completing hand hygiene, ULP-E put on a single clean glove and assisted R15 with perineal cares. ULP-E then removed soiled glove and without completing hand hygiene, assisted R15 to the sink to complete oral cares and hand washing. ULP-E then completed hand hygiene at sink prior to leaving room. On July 25, 2023, at 8:13 a.m., ULP-E stated that the dropped medication should have been disposed of, and the nurse should have been made aware of this drop. On July 25, 2023, at 8:35 a.m., ULP-E stated that	0 510		

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AMIRA CHOICE PLYMOUTH	18405 OLD ROCKFORD ROAD PLYMOUTH, MN 55446

(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
0 510	Continued From page 5 hand hygiene should be completed before cares, in between glove changes, and after completing cares. On July 26, 2023, at 12:19 a.m., CNS-C stated that staff are trained to complete hand hygiene before all cares or contact with resident and in between glove changes. Gloves should be used when coming into contact with residents, especially when coming into contact with bodily fluids. CNS-C stated that dropped medications should be secured and returned to the nursing office and then recorded in medication disposition log. The licensee's Standard Infection Control Precautions dated August 1, 2022, read, "Standard Precautions are used when encountering blood; body fluids, semen, vaginal secretions, and excretions except sweat (regardless of whether they contain visible blood); non-intact skin; and mucous membranes, whether visible blood is recognized. HAND WASHING: Proper hand washing is the most important way to break the chain of infection. Staff will wash hands: - After touching blood, body fluids, feces, or contaminated items (regardless of whether gloves are worn) - Before putting on gloves - Immediately after gloves or gowns are removed - As necessary, between tasks and procedures on the same client to prevent cross-contamination of different body sites, and between all client contacts GLOVES: Staff will wear clean gloves when touching blood, body fluids, feces, non-intact skin, mucous membranes, or contaminated items.	0 510		

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0 510	Continued From page 6 - Change gloves between tasks and procedures on the same client after contact with material that may contain a high concentration of microorganisms. - Remove gloves promptly after use, and before touching non-contaminated items, environmental surfaces, self, or other clients. - Wash hands after removing gloves." The Centers for Disease Control's (CDC), "CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings" dated November 29, 2022, under section 5a.2 (§ a, b, c, d, e, f) reads: 2.) Use an alcohol-based hand rub or wash with soap and water for the following clinical indications: a.) Immediately before touching a patient; b.) Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices; c.) Before moving from work on a soiled body site to a clean body site on the same patient; d.) After touching a patient or the patient's immediate environment; e.) After contact with blood, body fluids or contaminated surfaces; and f.) Immediately after glove removal. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
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	0 810		

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0 810	Continued From page 7 plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year 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 conduct required evacuation drills every other month. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a	0 810		

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0 810	Continued From page 8 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: An interview and record review were conducted on July 25, 2023, at approximately 11:00 a.m. with the Licensed Assisted Living Director (LALD)-D, the Environmental Services Director (ESD)-I, and the Assisted Living Director Intern (ALDI)-J on the fire safety and evacuation plan, fire safety and evacuation training for the facility, and fire safety and evacuation drills for the facility. Record review of the available documentation indicated that the licensee did not conduct evacuation drills twice per year per shift and every other month as required by statute. Provided documentation indicated that the drills were conducted on 1/23 (Second shift and third shift) and 6/26/23(First shift), with no further drills being documented. During the interview, ESD-I stated that the facility conducted a kitchen training on 3/28/23 and a Fire Extinguisher training on 5/30/23 but verified those training did not include evacuation drill contents. ESD-I verified that there were no further documented drills for the facility and verified this deficient condition. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		

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01620	Continued From page 9	01620		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing nursing assessments not to exceed every 90-days for four of six residents (R3, R8, R9, R14). 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	01620		

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01620	Continued From page 10 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: R3 R3 was admitted to the licensee and began receiving services on July 11, 2022. R3's diagnoses included dementia, syncope and collapse, hypertension, and anxiety. R3's service plan signed February 12, 2023, indicated R3 required assistance with compression stockings, bathing, medication administration, meals, toileting with one assist, denture care, grooming, dressing, bed making, homemaker service, housekeeping, and laundry. R3's record lacked timely 90-day nursing assessments. R3's last Assessment was dated April 17, 2023, which at the time of survey conclusion on July 27, 2023, was 101 days since last assessment. On July 25, 2023, at 8:52 a.m., clinical nurse supervisor (CNS)-C stated, "April 17, 2023, is the last assessment that was completed for her [R3], and I was going to look into that, and I haven't had a chance yet, I was thinking [R3] got off schedule because of an extra change of condition assessment was done and maybe the system didn't get updated properly with the next assessment date, so it was overlooked." R8 R8 admitted to licensee on April 22, 2022, and	01620		

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01620	Continued From page 11 began receiving assisted living services. R8's diagnoses included Type 2 diabetes mellitus, benign neoplasm (abnormal growth of tissue) of heart, and cerebral infarction (stroke). R8's Service Plan signed April 24, 2022, indicated R8 received assistance with bathing, meals, dressing, laundry, medication administration, blood glucose monitoring, transfer assistance of two, and toileting assistance. R8's record included 90-day nursing assessments dated April 20, 2023, and July 25, 2023, completed during the survey. The assessment completed on July 25, 2023, indicated 96 days had passed between assessments. R9 R9 admitted to licensee on October 6, 2021, and began receiving assisted living services. R9's diagnoses included pressure ulcer of sacral region stage 4, spinal stenosis, hypertension, urinary incontinence, anemia, and urine retention. R9's Service Plan signed October 7, 2021, indicated R9 received assistance with monitoring of wound vacuum function, bathing, meals, dressing, grooming, monthly vital signs, housekeeping, laundry, medication administration including as needed (PRN) medications, transfer assistance of two with use of mechanical lift, repositioning, heal protector placement, safety checks, toileting, and catheter care. R9's record included 90-day nursing assessments dated April 19, 2023, and July 25, 2023, completed during the survey. The	01620		

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01620	Continued From page 12 assessment completed on July 25, 2023, indicated 97 days had passed between assessments. R14 R14 was admitted to the licensee and began receiving services on December 17, 2019. R14 record lacked timely 90-day nursing assessments. R14's last Assessment was dated April 4, 2023, which at the time of survey conclusion was 114 days since last assessment. On July 24, 2023, at 10:10 a.m., during the entrance conference, CNS-C stated ongoing assessment were completed every 90 days however, the licensee scheduled assessments to be completed around day 80. On July 26, 2023, at 12:29 p.m., CNS-C stated they were unaware of why R8 and R9's ongoing assessment were late. On July 26, 2023, at 12:47 p.m., regional clinical nurse (RCN)-K stated there were staffing "issues" prior to the CNS employment with the licensee. In addition, RCN-K stated the licensee used agency RNs and the RNs may not have known how to reset the assessment schedule. The licensee's Assessment of Clients -Initial and Ongoing policy dated May 23, 2022, indicated ongoing client [resident] reassessment and monitoring would be conducted as needed, based on changes in the needs of the client [resident] and not to exceed 90 calendar days from the client's [resident's] last date of the uniform assessment. No further information provided.	01620		

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01620	Continued From page 13 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01640 SS=E	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the current service plan included a signature or other authentication by the resident or resident's designated representative to document agreement on the services to be provided for three of five residents (R3, R8, R9).	01640		

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01640	Continued From page 14 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R3 R3 was admitted to the licensee and began receiving services on July 11, 2022. R3's diagnoses included dementia, syncope and collapse, hypertension, and anxiety. R3's service plan signed February 12, 2023, indicated R3 required assistance with compression stockings, bathing, medication administration, meals, toileting with one assist, denture care, grooming, dressing, bed making, homemaker service, housekeeping, and laundry. R3's unsigned service plan dated July 26, 2023, indicated R3 required assistance with medication administration, escort, bed mobility: physical assist of one, transfer assist: one person with lift, dressing: brace assist, dressing: physical assist of one, TED Hose/Wrap: physical assist of one, denture care: physical assist of one, toileting: physical assist of one, grooming: physical assist of one, bed making, homemaker service, housekeeping, and laundry. On July 25, 2023, at 6:50 a.m., surveyor	01640		

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01640	Continued From page 15 observed unlicensed personnel (ULP)-H provide morning cares and transfer R3 with assist of one and standing lift. R8 R8 admitted to licensee on April 22, 2022, and began receiving assisted living services. R8's diagnoses included Type 2 diabetes mellitus, benign neoplasm (abnormal growth of tissue) of heart, and cerebral infarction (stroke). R8's Service Plan signed April 24, 2022, indicated R8 received assistance with bathing, meals, dressing assist of one, grooming assist of one, laundry, medication administration, blood glucose monitoring, transfer assistance of two, safety check, and toileting assist of two. R8's unsigned Service Plan effective date July 16, 2023, indicated R8 received assistance with diabetic management, activities assist of one, exercise program, phone assistance, technology assistance, bathing assistance, meals, dressing assist of one, vision aid assist of one, grooming assist of one, nail care, oral care assist of one, monthly vital signs, bed making, housekeeping, trash removal, laundry, blood glucose assist, medication administration, assist of one for mobility via wheelchair, transfer assist of one with stand lift assist, safety check, and toileting assist of one. On July 25, 2023, from 7:24 a.m. to 7:59 a.m., the surveyor observed ULP-G transfer and toilet R8 with assist of one. R9 R9 admitted to licensee on October 6, 2021, and began receiving assisted living services.	01640		

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01640	Continued From page 16 R9's diagnoses included pressure ulcer of sacral region stage 4, spinal stenosis, hypertension, urinary incontinence, anemia, and urine retention. R9's Service Plan signed October 7, 2021, indicated R9 received assistance with monitoring of wound vacuum function, bathing, meals, dressing, grooming, monthly vital signs, housekeeping, laundry, medication administration including as needed (PRN) medications, transfer assistance of two with use of mechanical lift, repositioning, heal protector placement, safety checks, toileting, and catheter care. R9's unsigned Service Plan dated July 26, 2023, indicated R9 received assistance with range of motion, bathing assist of one, meals, dressing assist of one, assist of one for grooming, nail care, oral care, monthly vital signs, podiatry, cleaning of assistive devices, bed making, housekeeping, laundry, medication administration, bed mobility assist of two, repositioning, placement of heal protectors, transfers assist of two with mechanical lift, toileting assist of one, and catheter cares. On July 26, 2023, at 9:25 a.m., the surveyor observed a bordered foam dressing on R9's sacrum. On July 26, 2023, at 9:28 a.m., R9 stated they never had a wound vacuum applied to their sacrum because the wound care certified nurse told them it was not needed. R3, R8, and R9's service plans lacked a signature or other authentication by the resident or resident's designated representative and the licensee to document agreement on the services	01640		

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01640	Continued From page 17 to be provided when revisions occurred. On July 26, 2023, 12:21 p.m., clinical nurse supervisor (CNS)-C stated resident's service plans were completed after a nursing assessment was conducted and if there was a change to service level or a change in condition. The surveyor inquired what occurred if there was a change in the service plan. CNS-C stated nurses would contact resident or resident family and review services needed and the cost level. If the resident did not want to receive a service recommended that would be documented in the chart and if they agreed to services, they would sign a new service plan. The surveyor inquired when they would have the resident or resident family member sign the service plan. CNS-C stated, "when the services start." In addition, CNS-C verified that R3, R8, R9's records lacked a current up-to-date signed service plan. The licensee's Service Plan Agreement Development and Revision policy dated December 2, 2020, read, "When Service Plan Agreement approval must be obtained from client [resident] representative and they are not available on site to sign the agreement the following process is acceptable: - RN communicates changes in Service Plan to client representative and obtains approval for implementation - Documentation of this approval is noted in the client medical record - Services may be implemented with such approval - RN and client representative agree upon the most timely method to obtain the required client representative signature on Service Plan Agreement - Options for an expeditious signature include, but	01640		

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01640	Continued From page 18 are not limited to; scheduling an in person meeting at the site, securely faxing the document or mailing the document - The RN will have a tracking method to ensure the required signature is on file in a timely manner." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01730 SS=D	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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(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 19 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 and maintain a current individualized medication management record for each resident to include all required content for two of six residents (R9, R14). 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: R9 R9 admitted to licensee October 6, 2021, and	01730		

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	33599	A. BUILDING: _____ B. WING _____	07/27/2023

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01730	Continued From page 20 started receiving assisted living services. R9's diagnoses included pressure ulcer of sacral region stage 4, spinal stenosis, hypertension, urinary incontinence, anemia, and urine retention. R9's Service Plan signed October 7, 2021, indicated R9 received assistance with monitoring of wound vacuum function, bathing, meals, dressing, grooming, monthly vital signs, housekeeping, laundry, medication administration including as needed (PRN) medications, transfer assistance of two with use of mechanical lift, repositioning, heal protector placement, safety checks, toileting, and catheter care. On July 25, 2023, at 8:32 a.m., the surveyor observed unlicensed personnel (ULP)-G administer oral medications to R9. R9's Medication Sheet dated July 1, through July 31, 2023, included fentanyl 75 microgram (mcg) patch for pain, apply transdermally every 72 hours remove old patch before applying new one, wear gloves, and Biofreeze gel 4 percent (%) apply to affected area topically two times per day PRN. R9's provider orders signed June 27, 2023, included Biofreeze 4 % topical gel apply to affected area two times per day PRN topically for pain and Fentanyl 75 mcg/ hour (h) transdermal patch apply one patch transdermally every 72 hours for pain. R9 Service Plan dated October 7, 2021, Comprehensive Assessment / Licensed Services dated April 19, 2023, Medication Sheet dated July 1, 2023, and Service Checkoff List dated July 1 through July 31, 2023, included parts of the	01730		

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01730	Continued From page 21 individualized medication management record however, lacked specific resident instructions relating to the medication administration. On July 26, 2023, at 9:18 a.m., ULP-E stated R9's Biofreeze was applied to the lower back and the fentanyl patch was applied to the front of the shoulder and rotated from right to left shoulder every three days. The surveyor inquired where they located this information. ULP-E stated they should be able to see it in the electronic medical record (EMAR) however, R9's EMAR did not include it. In addition, they believe they were told where to apply the medications. R14 R14 admitted to the licensee and began receiving services on December 17, 2019. R14's diagnoses included hypertension, thoracic aortic aneurysm without rupture, vascular dementia, depression due to dementia, and anxiety. R14's Service Plan Agreement signed May 11, 2022, indicated R14 received assistance with showering, dressing/undressing, grooming, homemaking services, bed making, transfer assist of two, toileting, laundry, and medication administration. On July 25, 2023, at approximately 8:59 a.m., the surveyor observed ULP-B administer oral medications, topical diclofenac gel 1%, and eye drops to R14. R14's Individualized Medication Management plan dated April 4, 2023, lacked documentation of specific resident instructions relating to the administration of topical medications.	01730		

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01730	Continued From page 22 On July 26, 2023, at 12:31 p.m., clinical nursing supervisor (CNS)-C stated transdermal medication could be applied to any location that was safe for transdermal application. In addition, for topical medication they would expect there to be a specific location listed. CNS-C verified R9's record lacked specific instructions related to medication administration and was unaware of why this occurred but believed it was due to the way the order was written. CNS-C stated their process would be to enter specific instructions that ULP would be able to see on the electronic medical record (EMAR). The licensee's Medication Management Services policy dated August 1, 2021, indicated based on the nursing assessment, the registered nurse (RN) would develop and individualized medication management plan for each client [resident] receiving any type of medication management services, consistent with current practice standards and guidelines, and will develop specific procedures for medication management services that the staff would provide. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation	01760		

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01760	Continued From page 23 must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered per providers orders for two of six residents (R9, R14). 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: R8 R8 admitted to licensee on April 22, 2022, and began receiving assisted living services. R8's diagnoses included Type 2 diabetes mellitus, benign neoplasm (abnormal growth of tissue) of heart, and cerebral infarction (stroke). R8's Service Plan signed April 24, 2022, indicated R8 received assistance with bathing, meals, dressing, laundry, medication administration,	01760		

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01760	Continued From page 24 blood glucose monitoring, transfer assistance of two, and toileting assistance. R8's provider orders signed April 19, 2023, included Alphagan P 0.1 percent (%) solution, instill one drop into the left eye two times per day. On July 25, 2023, at 8:54 a.m., the surveyor observed unlicensed personnel (ULP)-G administer one drop of Alphagan P 0.1 % solution into R8's right and left eye. On July 25, 2023, at 9:04 a.m., the surveyor inquired which eye Alphagan P 0.1 % solution should be applied to. ULP-G stated "oh man it was only supposed to be one. I thought it was for two like the other one." ULP-G stated they would contact the nurse about the medication error. R14 R14 admitted for assisted living services on December 17, 2019. R14's diagnoses included hypertension, thoracic aortic aneurysm without rupture, vascular dementia, depression due to dementia, and anxiety. R14's Service Plan Agreement signed May 11, 2022, indicated R14 received assistance with showering, dressing/undressing, grooming, homemaking services, bed making, transfer assist of two, toileting, laundry, and medication administration. R14's physician order signed January 31, 2023, included diclofenac gel one percent (%) one gram (gm) topically to shoulder two times daily. On July 25, 2023, at 8:18 a.m., surveyor	01760		

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01760	Continued From page 25 observed ULP-B place an unmeasured small circular amount of diclofenac gel 1% directly onto their gloved hand and rubbed the gel onto both of R14's shoulders. The surveyor inquired how diclofenac sodium 1% was measured. ULP-B stated, "we are supposed to use a strip to measure it, but that strip is gone now so we can't measure but I normally do so that we have the correct amount, so I know amount I need to use without it." On July 25, 2023, at 8:49 a.m., clinical nurse supervisor (CNS)-C stated, "There is a dosing card in each package, and they should apply a thin line to the card and apply from there clean the card and put the card back. The aide grabbed me a few minutes ago and informed me it was missing, we found it and it is back in the bag for use." On July 26, 2023, at 12:24 p.m., CNS-C stated ULP received medication training during onboarding, at the facility by shadowing another employee, and received a competency completed by a RN utilizing the 5 rights of medication administration. In addition, CNS-C stated ULP should administer medications per provider orders. The licensee's Medication and Treatment Implementation policy dated August 1, 2021, indicated the RN was responsible for assuring that the prescriptions and orders have been implemented appropriately through client [resident] monitoring, supervision of staff and review of client [resident] records. The licensee's Unlicensed Personnel - Medication Administration policy dated August 1, 2021, read, "Medication always need to be	01760		

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01760	Continued From page 26 administered according to the "5 Rights." a. Right person b. Right medication c. Right time d. Right route (by mouth, eye drops, topical, etc.) e. Right dose (how many milligrams, drops, etc.)" No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01880 SS=D	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure all medications were securely locked in substantially constructed compartments and permitted only authorized personnel to have access for one of nine residents (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 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).	01880		

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01880	Continued From page 27 The findings include: R9 admitted to licensee October 6, 2021, and started receiving assisted living services. R9's Service Plan signed October 7, 2021, indicated R9 received assistance with monitoring of wound vacuum function, bathing, meals, dressing, grooming, monthly vital signs, housekeeping, laundry, medication administration including as needed (PRN) medications, transfer assistance of two with use of mechanical lift, repositioning, heal protector placement, safety checks, toileting, and catheter care. R9's Comprehensive Assessment /Licensed Services dated April 19, 2023, indicated R9's medications were kept in a locked medication cart and controlled medications were secured with a double lock system. On July 25, 2023, at 8:32 a.m., the surveyor observed nystatin 100,000 units (u) per gram (g), one tube of calmoseptine ointment, and one bottle approximately half full of antiacid 750 milligrams (mg) containing an unknown quantity of medication unlocked and unsecure on R9's bedside tables. On July 25, 2023, at 8:37 a.m., unlicensed personnel (ULP)-G stated the electronic medication administration record (EMAR) would indicate if a resident could have medications left in room. The surveyor inquired if R9's EMAR indicated medication could be left in room. ULP-G stated no. The surveyor inquired if they knew why R9's medication listed above was left in R9's room. ULP-G stated they were unaware of why however, there may be something on the evening EMAR that stated to leave medication in the	01880		

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01880	Continued From page 28 room. On July 26, 2023, at 12:27 p.m., clinical nurse supervisor (CNS)-C stated if a resident's medication could be left in the resident's room there would be a note in the chart otherwise it should be locked in the medication cart. The licensee's Storage of Medication and Key Security dated April 19, 2023, indicated the nurse would identify where the medications will be stored in the client's [resident's] individualized medication management plan. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
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 discard expired medication for one of fourteen residents (R11) and failed to ensure time sensitive medications were labeled with the date opened for one of fourteen residents (R10) with time sensitive medication.	01890		

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01890	Continued From page 29 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On July 24, 2023, at 12:58 p.m., the surveyor observed the third-floor medication cart and observed the following: EXPIRED MEDICATION: -R11 Hyoscyamine 0.215 milligrams (mg) with an expiration date of July 19, 2023. UNLABELED TIME SENSITIVE MEDICATION: -R10 one bottle of Alphagan OP 0.1 % solution On July 24, 2023, at 1:06 p.m., unlicensed personnel (ULP)-E stated medications were used until the expiration date on the eye drop bottle, and then nursing would bring a new eye drop bottle to them. In addition, if they noticed an expired medication, they would bring the medication to the nurse to destroy. On July 26th, 2023, at 12:28 p.m., clinical nurse supervisor (CNS)-C stated staff were trained to date medications time sensitive medications upon opening, and nurses audited the medication carts routinely. The manufacturer's instructions for Alphagan eye drops dated December 1, 2014, recommended Alphangan eye drops be discarded four weeks	01890		

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01890	Continued From page 30 after first use. The licensee's Storage of Medication and Key Security policy dated April 19, 2023, indicated until the medication is set up for immediate or later administration by a nurse, a legend drug must be kept in its original container bearing the original prescription label with legible information stating the prescription number, name of drug, strength and quantity of drug, expiration date of time-dated drug, directions for use, client's name, prescriber's name, date of issue and the name and address of the licensed pharmacy that issued the medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
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	02040		

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02040	Continued From page 31 licensee fails to protect the residents according to the hazard vulnerability assessment mitigation factor. 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 of the available documentation and interview was conducted on July 25, 2023, at approximately 11:00 a.m. with the Licensed Assisted Living Director (LALD)-D, the Environmental Services Director (ESD)-I, and the Assisted Living Director Intern (ALDI)-J on the hazard vulnerability assessment for the physical environment of the facility. The record review indicated that the licensee had performed a hazard vulnerability assessment with mitigation factors on and around the property but failed to protect the residents according to the hazard vulnerability assessment mitigation factor. During the facility tour with the Environmental Services Director (ESD)-I and the Assisted Living Director Intern (ALDI)-J on July 25, 2023, at approximately 9:00 a.m., it was observed that the oven in the memory care dining room was not disconnected during times when the kitchen was not staffed. The kitchen was accessible by residents without any secured gate. During the interview, the dining staff and EDS-I were not aware of the shut-off function of the oven.	02040		

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02040	Continued From page 32 Record review of the available documentation, the memory care oven protection protocol was in the hazard vulnerability assessment list, and the mitigation factor was listed as turning off the safety switch when not in use and staff supervision required during use. During the interview, LALD-D confirmed that the facility failed to protect the residents according to the hazard vulnerability assessment mitigation factor. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical or nursing standards for three of three residents (R3, R8, R9) with consumer bed rails and assistive devices. 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	02310	On July 26, 2023, the immediacy of correction order 2310 was removed, however non-compliance remained at a level three, widespread violation.	

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02310	Continued From page 33 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: R3 R3 had diagnoses to include syncope and collapse, anxiety, and hypertension. R3's signed Service Plan Agreement dated February 1, 2023, indicated R3 received bathing dressing, TED Hose, grooming, oral care set up, homemaker services, housekeeping, toileting, laundry, and medication administration. On July 25, 2023, at 6:50 a.m., the surveyor observed R3's bed had Halo Safety Ring bed rails (consumer bed rail) at the top of the bed on each side of the bed. The bed rails were firmly attached to the bed. R3 stated, "I use those to help me get out of bed or move around, otherwise it can get quite difficult to get out of bed in the morning." R3's Basic Assessment dated April 17, 2023, indicated R3 did not have bed rails. R8 R8's diagnoses included Type 2 diabetes mellitus, benign neoplasm (abnormal growth of tissue) of heart, and cerebral infarction (stroke). R8's Service Plan signed April 24, 2022, indicated R8 received assistance with bathing, meals, dressing, laundry, medication administration, blood glucose monitoring, transfer assistance of two, and toileting assistance.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33599	A. BUILDING: _____ B. WING _____	07/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMIRA CHOICE PLYMOUTH	18405 OLD ROCKFORD ROAD PLYMOUTH, MN 55446

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 34 On July 25, 2023, at 7:24 a.m., the surveyor observed R8's bed had Halo Safety Ring bed rails (consumer bed rail) at the top of the bed on each side of the bed. The bed rails were firmly attached to the bed. R9 R9's diagnoses included pressure ulcer of sacral region stage 4, spinal stenosis, hypertension, urinary incontinence, anemia, and urine retention. R9's Service Plan signed October 7, 2021, indicated R9 received assistance with bathing, meals, dressing, grooming, housekeeping, laundry, medication administration, transfer assistance of two, repositioning, toileting, and catheter care. On July 25, 2023, at 9:10 a.m., the surveyor observed R9's hospital bed with square consumer bed rails of unknown manufacturer origin at the top of the bed on each side of the bed. The bed rails were firmly attached to the bed. R3, R8, and R9's record lacked: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Installation and use according to manufacturer's guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33599	A. BUILDING: _____ B. WING _____	07/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMIRA CHOICE PLYMOUTH	18405 OLD ROCKFORD ROAD PLYMOUTH, MN 55446

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 35 interventions to mitigate safety risk or negotiated risk agreements. On July 25, 2023, at 8:52 a.m., clinical nurse supervisor, (CNS)-C stated April 17, 2023, was the last assessment that was completed for R3, and CNS-C intended to look into that, but had not had a chance yet. CNS-C stated R3's assessments may have gotten off schedule because an extra change of condition assessment was done, and the system may not have updated properly with the next assessment date, so it was overlooked. CNS-C stated the bed rail assessment is wrapped up in the basic assessments the licensee does, so if one was done, it would be in there. Additionally, CNS-C stated they were not aware that R3 had bed rails. CNS-C stated they knew the interim director of health services did an audit on bedrails, but did not know off hand how many were in the building. On July 25, 2023, at 10:00 a.m., CNS-C stated, "I didn't print the assessments for [R8] and [R9] because they do not have bed rail assessments done. I spoke to the nurses, and they told me that they were under the impression that if it was a Halo, it wasn't a bedrail, so it didn't need to be assessed, so none of them have been assessed." The Food and Drug Administration (FDA) guidance A Guide to Bed Safety dated 2000, and revised April 2010, indicated following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33599	A. BUILDING: _____ B. WING _____	07/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMIRA CHOICE PLYMOUTH	18405 OLD ROCKFORD ROAD PLYMOUTH, MN 55446

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 36 best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently Asked Questions (FAQs) indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." The MDH website indicated for consumer bed rails, the licensee must include in their documentation: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Installation and use according to manufacturer's guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". The licensee's Assessment and Use of Side Rails	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33599	A. BUILDING: _____ B. WING _____	07/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02310	Continued From page 37 dated January December 2, 2020, indicated staff would alert the nurse if a resident had any type of bed rail or similar equipment and the nurse would evaluate whether the bed rail appeared to be appropriate for the resident. The nurse would educate the resident, their representative and/or family members about the risks related to bed rails, and if the resident's bed rails did not meet standards, the nurse remove the siderail and would recommend alternative options. The nurse will document these conversations and recommendations. TIME PERIOD FOR CORRECTION: IMMEDIATE	02310		

Minnesota Department of Health

625 North Robert Street
Saint Paul, MN
651-201-5000

Type: Full
Date: *07/24/23*
Time: 16:00:00
Report: 8087231185

Food and Beverage Establishment Inspection Report

Location:

Cherrywood Pointe Of Plymouth
18405 Old Rockford Road
Plymouth, MN55446
Hennepin County, 27

Establishment Info:

ID #: 0038314
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7634784244
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.

2-100 Supervision

2-102.12AMN

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

THERE IS NO FULL TIME STATE CERTIFIED FOOD PROTECTION MANAGER AT THE ESTABLISHMENT. HIRE A FULL TIME EMPLOYEE OR TRAIN AN EXISTING FULL TIME EMPLOYEE AND APPLY FOR THE STATE CERTIFIED FOOD PROTECTION MANAGER CERTIFICATE.

Comply By: 09/01/23

Surface and Equipment Sanitizers

Quaternary Ammonia: = 200 PPM at -- Degrees Fahrenheit
Location: WIPING CLOTH BUCKET
Violation Issued: No

Wash Temperature Gauge: = -- at 160 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Wash Temperature Gauge: = -- at 188 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Max Utensil Surface Temp: = -- at 164 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Type: Full
Date: *07/24/23*
Time: 16:00:00
Report: 8087231185
Cherrywood Pointe Of Plymouth

Food and Beverage Establishment Inspection Report

Process/Item: Ambient Air
Temperature: 38 Degrees Fahrenheit - Location: STAND-UP COOLER #1
Violation Issued: No

Process/Item: Cold Holding: COLESLAW
Temperature: 41 Degrees Fahrenheit - Location: STAND-UP COOLER #1
Violation Issued: No

Process/Item: Cold Holding: PIE
Temperature: 40 Degrees Fahrenheit - Location: STAND-UP COOLER #1
Violation Issued: No

Process/Item: Ambient Air
Temperature: 4 Degrees Fahrenheit - Location: ICE CREAM FREEZER #1
Violation Issued: No

Process/Item: Ambient Air
Temperature: 18 Degrees Fahrenheit - Location: ICE CREAM FREEZER #2
Violation Issued: No

Process/Item: Ambient Air
Temperature: 36 Degrees Fahrenheit - Location: STAND-UP COOLER #2
Violation Issued: No

Process/Item: Cold Holding: WHIP CREAM
Temperature: 40 Degrees Fahrenheit - Location: STAND-UP COOLER #2
Violation Issued: No

Process/Item: Cold Holding: PIE
Temperature: 39 Degrees Fahrenheit - Location: STAND-UP COOLER #2
Violation Issued: No

Process/Item: Ambient Air
Temperature: 5 Degrees Fahrenheit - Location: WALK-IN FREEZER
Violation Issued: No

Process/Item: Ambient Air
Temperature: 42 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Holding: MILK
Temperature: 40 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Holding: YOGURT
Temperature: 40 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Holding: CHEESE
Temperature: 40 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Holding: CUT MELON
Temperature: 41 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Hot Holding: SOUP
Temperature: 173 Degrees Fahrenheit - Location: SOUP WARMER
Violation Issued: No

Process/Item: Ambient Air
Temperature: 12 Degrees Fahrenheit - Location: STAND-UP FRYER FREEZER
Violation Issued: No

Process/Item: Ambient Air
Temperature: 33 Degrees Fahrenheit - Location: STAND-UP COOLER #3
Violation Issued: No

Process/Item: Cold Holding: MILK
Temperature: 39 Degrees Fahrenheit - Location: STAND-UP COOLER #3
Violation Issued: No

Process/Item: Cold Holding: CUT LFY GRN
Temperature: 34 Degrees Fahrenheit - Location: STAND-UP COOLER #3
Violation Issued: No

Process/Item: Cold Holding: PIE
Temperature: 33 Degrees Fahrenheit - Location: STAND-UP COOLER #3
Violation Issued: No

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

THIS WAS AN UNANNOUNCED AND UNSCHEDULED FULL INSPECTION.

INSPECTION DONE WITH KITCHEN MANAGER LUKE CASWELL.

TOPICS OF DISCUSSION WITH OPERATOR INCLUDED:

HAND WASHING
NOROVIRUS
BARE HAND CONTACT WITH READY TO EAT FOODS
EMPLOYEE ILLNESS
EMPLOYEE EXCLUSION
COOLING METHODS
REHEATING METHODS
SANITIZER CONCENTRATION
DATE MARKING
ALL ITEMS ON THIS REPORT
ALL ITEMS ON PREVIOUS REPORT

ALL FROZEN FOODS FOUND IN FROZEN CONDITION.

REPORT EMAILED TO ESTABLISHMENT.

Type: Full
Date: *07/24/23*
Time: 16:00:00
Report: 8087231185
Cherrywood Pointe Of Plymouth

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 8087231185 of 07/24/23.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed:_____
LUKE CASWELL
KITCHEN MANAGER

Signed:_____
John Boettcher
Public Health Sanitarian 3
St. Paul, MN / Freeman
651-201-5076
john.boettcher@state.mn.us