Electronically Delivered

November 30, 2023

Licensee
Burnsville Carefree Living
600 East Nicollet Boulevard
Burnsville, MN 55337

RE: Project Number(s) SL20191015

Dear Licensee:

On November 14, 2023, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the June 22, 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,

Jessie Chenze, Supervisor
State Evaluation Team
Email: jessie.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20191	A. BUILDING: _____ B. WING _____	R 11/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BURNSVILLE CAREFREE LIVING	600 EAST NICOLLET BOULEVARD BURNSVILLE, MN 55337

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: Project # SL20191015-2 On November 14, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed between September 6, and September 7, 2023. At the time of the survey, there were 94 active residents receiving services under the Assisted Living/ with Dementia Care license. As a result of the revisit, the licensee is in substantial compliance.	{0 000}		
{01500} SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include:	{01500}		

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

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{01500}	Continued From page 2 age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: No further action needed.	{01500}		
{01550} SS=F	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (4) staff who do not provide direct care, including maintenance, housekeeping, and food service staff, must have at least four hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; and This MN Requirement is not met as evidenced by: No further action needed.	{01550}		
{01750} SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated	{01750}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{01750}	Continued From page 3 the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: No further action needed.	{01750}		
{01880} SS=E	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 needed.	{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 needed.	{01890}		
{01950} SS=F	144G.72 Subd. 4 Administration of treatments	{01950}		

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{01950}	Continued From page 4 and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: No further action needed.	{01950}		

Electronically Delivered

September 26, 2023

Licensee
Burnsville Carefree Living
600 East Nicollet Boulevard
Burnsville, MN 55337

RE: Project Number(s) SL20191015

Dear Licensee:

On September 7, 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 June 22, 2023. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the June 22, 2023 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey completed on June 22, 2023, found not corrected at the time of the September 7, 2023, follow-up survey and/or subject to penalty assessment are as follows:

0800-Fire Protection And Physical Environment-144g.45 Subd. 2 (a) (4)

The details of the violations noted at the time of this follow-up survey completed on September 7, 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.

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

DOCUMENTATION OF ACTION TO COMPLY

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

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

We urge you to review these orders carefully. If you have questions, please contact Jessie Chenze at 218-332-5175.

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,

Jessie Chenze

Jessie Chenze, Supervisor
State Evaluation Team
Email: jessie.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 651-281-9796

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20191	A. BUILDING: _____ B. WING _____	R 09/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BURNSVILLE CAREFREE LIVING	600 EAST NICOLLET BOULEVARD BURNSVILLE, MN 55337

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: Project SL20191015-1 On September 6, through September 7, 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 June 22, 2023. At the time of the survey, there were 94 residents receiving 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	
{0 800} SS=C	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including	{0 800}		

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BURNSVILLE CAREFREE LIVING	600 EAST NICOLLET BOULEVARD BURNSVILLE, MN 55337

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{0 800}	Continued From page 1 walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). Findings include: On a facility tour on September 6, 2023, at approximately 2:00 p.m. with maintenance supervisor (MS)-M a passive air vent open to the corridor was observed cut into the fire resistant rated mechanical room door across from resident room 117. Fire resistant rated doors are required to be maintained as designed and installed at the time of construction approval. It was also observed the closers were removed from the kitchen storage room door to the corridor and the mechanical room door near	{0 800}		

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{0 800}	Continued From page 2 resident room 117. Fire resistant rated doors are required to close and latch automatically as designed and installed at the time of construction approval. Water damage from a roof leak was observed in the dining room on the wall near the windows of the higher raised ceiling area. Paint was observed pealing and flaking from the ceiling in the kitchen storage room. These deficient conditions were visually verified by MS-M accompanying on the tour.	{0 800}		
{01500} SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases;	{01500}		

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{01500}	Continued From page 3 (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: No further action needed.	{01500}		

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{01550}	Continued From page 4	{01550}		
{01550} SS=F	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (4) staff who do not provide direct care, including maintenance, housekeeping, and food service staff, must have at least four hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; and This MN Requirement is not met as evidenced by: No further action needed.	{01550}		
{01750} SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: No further action needed.	{01750}		
{01880} SS=E	144G.71 Subd. 19 Storage of medications An assisted living facility must store all	{01880}		

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{01880}	Continued From page 5 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 needed.	{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 needed.	{01890}		
{01950} SS=F	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the	{01950}		

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{01950}	Continued From page 6 proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: No further action needed.	{01950}		

Electronically Delivered

July 11, 2023

Licensee
Burnsville Carefree Living
600 East Nicollet Boulevard
Burnsville, MN 55337

RE: Project Number(s) SL20191015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 22, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

The correction order documentation should include the following:

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

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

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

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

Please address your cover letter for reconsideration requests to:

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

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

If you have any questions, please contact me.

Sincerely,

Jessie Chenze

Jessie Chenze, Supervisor
State Evaluation Team
Email: jessie.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 651-281-9796

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20191	A. BUILDING: _____ B. WING _____	06/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BURNSVILLE CAREFREE LIVING	600 EAST NICOLLET BOULEVARD BURNSVILLE, MN 55337

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL20191015-0 On June 20, 2023, through June 22, 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 59 receiving services under the Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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.	
0 780 SS=D	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with	0 780		

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0 780	Continued From page 1 the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms outside and in the immediate vicinity of sleeping rooms. This deficient condition had the ability to affect a limited number of staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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	0 780		

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0 780	Continued From page 2 only occasionally). Findings include: On a facility tour on June 21, 2023, at approximately 12:00 p.m. with licensed assisted living director (LALD)-A it was observed that a smoke alarm was not installed outside and in the immediate vicinity of the sleeping room in resident sleeping unit 318. Smoke alarms are required to be located outside and in the immediate vicinity of sleeping rooms and interconnected so activation of one alarm activates all alarms throughout the sleeping unit. This deficient finding was visually verified by LALD-A at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and	0 800		

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0 800	Continued From page 3 well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On a facility tour on June 20, 2023, at approximately 11:30 a.m. with licensed assisted living director (LALD)-A the bathroom fan was loud and in need of repair in resident room 223 bathroom. Bathroom fans are required to be maintained in order to provide exhaust from the bathroom. On the same tour it was observed door closers were removed from several fire-resistant rated doors. The room observed with closers removed were the salon, resident rooms 239 and 336, laundry room, chapel door from dining room side, door from kitchen storage to corridor and mechanical room door near resident room 117. Fire resistant rated door assemblies are required to close and to be maintained according to design and installation at time of construction approval. A passive air vent open to the corridor was observed cut into the fire resistant rated mechanical room door across from resident room 117. Fire resistant rated doors are required to be maintained as designed and installed at the time of construction approval.	0 800		

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0 800	Continued From page 4 A door wedge was observed on the fire-resistant rated door of the electrical/server room door. It was stated by LALD-A the door was wedged open because of excessive heat produced by equipment in the room. Fire resistant rated door assemblies are required to close and latch and to be maintained according to design and installation at time of construction approval. Water damage from a roof leak was observed in the dining room on the wall near the windows of the higher raised ceiling area. Paint was observed pealing and flaking from the ceiling in the kitchen storage room. A light fixture was observed with the globe cover missing in the mechanical room near resident room 129. Light fixtures are required to be maintained according to manufactures installation instructions. These deficient conditions were visually verified by LALD-A accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for	0 810		

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0 810	Continued From page 5 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 record review and interview, the licensee failed to maintain the facility's fire safety and evacuation plan with required elements. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	0 810		

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0 810	Continued From page 6 or has potential to affect a large portion or all of the residents). Findings include: A record review of available documentation and interview were conducted on June 21, 2023, at approximately 10:30 a.m. of documents provided by licensed assisted living director (LALD)-A on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of the available documentation indicated that employees did not receive training upon initial hire and twice per year thereafter on the facility fire safety and evacuation plan. Employee training is required to be documented separately from drills. Record review of the available documentation indicated that evacuation drills had been conducted but not in the required sequence of twice per year per shift and at least once every other month. Documentation was provided indicating 2 drills were completed in April and 1 in May for 2023 no other drill documentation was provided. All deficiencies were verified by LALD-A during the interview at approximately 11:00 a.m. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 820 SS=D	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including	0 820		

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0 820	Continued From page 7 assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide facilities that were not a distinct hazard to life. This had the potential to affect a limited number of residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). Findings include: On a facility tour on June 21, 2023, at approximately 12:00 p.m. with licensed assisted living director (LALD)-A, it was also observed an exterior exit gate from the secure outdoor patio area was provided with a cable lock and a lever handle lock. Gates or doors in the exterior exit path to the public way are required to operate with hardware on the interior of the gate, the same as the building exterior exit doors and	0 820		

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0 820	Continued From page 8 release to open in one operation. All clinical staff are required to carry a key to release the latch of the secured gate for egress. This deficient condition was verified by LALD-A accompanying on the tour. TIME PERIOD FOR CORRECTION: Two (2) days	0 820		
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's	01500		

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01500	Continued From page 9 disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an employee received all of the required annual training content for each 12 months of employment for two of two employees (unlicensed personnel (ULP)-D, ULP-J). This practice resulted in a level two violation (a	01500		

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01500	Continued From page 10 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-D ULP-D started employment on September 8, 2014, and began providing assisted living services on August 1, 2021. On June 21, 2023, at 7:27 a.m., the surveyor observed ULP-D administer R3's morning medication, check R3's blood glucose level, and apply a compression stocking to R3's left leg. ULP-D's employee record lacked evidence ULP-D successfully completed annual training as required to include: -training on reporting of maltreatment of vulnerable adults under section 626.557 -review of infection control techniques used in the home and implementation of infection control standards included a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person -a review of the facility's policies and procedures	01500		

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01500	Continued From page 11 relating to the provision of assisted living services and how to implement those policies and procedures ULP-J ULP-J started employment on June 8, 2017, and began providing assisted living services on August 1, 2021. On June 21, 2023, at 9:50 a.m., the surveyor observed ULP-J administer R6's morning medication. ULP-J's employee record lacked evidence ULP-J successfully completed annual training as required to include: -review of infection control techniques used in the home and implementation of infection control standards included a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person -a review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures. On June 22, 2023, at 9:18 a.m., licensed practical nurse (LPN)- M stated ULP-D did not complete the required annual training. On June 22, 2023, at 9:25 a.m., LPN-M stated ULP-J did not complete the required annual	01500		

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01500	Continued From page 12 training. LPN-M added she does not assign the classes for the ULPs however she stated it was a widespread issue. The licensee's Training and Competency of Unlicensed Staff policy revised January 16, 2023, noted all staff that perform direct services must complete at least eight hours of annual training or each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: -training on reporting of maltreatment of vulnerable adults -review of infection control techniques used in the home and implementation of infection control standards included a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person -a review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		

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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
01550	Continued From page 13	01550		
01550 SS=F	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (4) staff who do not provide direct care, including maintenance, housekeeping, and food service staff, must have at least four hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees that did not provide direct care, received at least four hours of initial training on dementia care within 160 working hours of the employment start date, for two of two employees (dietary aide (DA)-K, community enrichment coordinator (CEC)-L). 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: During the entrance conference on June 20, 2023, at 12:06 p.m., licensed assisted living director (LALD)-A stated the licensee provided services to residents with dementia and other related disorders, adding "it is my life."	01550		

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01550	Continued From page 14 DA-K DA-K started employment on January 19, 2022. DA-K's employee record included: -Alzheimer's Disease and Dementia Care Training, one (1) hour -Alzheimer's Disease and Related Disorders: Behavior Management, one (1) hour -Dementia Care: Performing ADLs (activities of daily living), 0.5 hour -Dementia Care: Understanding Alzheimer's Disease, 0.5 hour A total of three (3) hours. On June 22, 2023, at 9:55 a.m., LALD-A stated DA-K had worked a total of 160 hours on December 3, 2022. LALD-A added DA-K had taken a lot of time off. DA-K's employee record lacked evidence DA-K completed the required four hours of dementia training within 160 hours of DA-K's hire date. On June 22, 2023, at 9:56 a.m., licensed practical nurse (LPN)-M stated DA-K completed three (3) hours of dementia training. LPN-M said DA-K did not complete dementia training as required. CEC-L CEC-L started employment on February 14, 2022. CEC-L's employee record included: -Alzheimer's Disease and Dementia Care Training, one (1) hour -Alzheimer's Disease and Related Disorders: Behavior Management, one (1) hour -Dementia Care: Performing ADLs (activities of daily living), 0.5 hour -Dementia Care: Understanding Alzheimer's	01550		

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01550	Continued From page 15 Disease, 0.5 hour A total of three (3) hours. On June 22, 2023, at 11:06 a.m., LALD-A stated CEC-L had worked a total of 160 hours on February 25, 2022. CEC-L's employee record lacked evidence CEC-L completed the required four hours of dementia training within 160 hours of CEC-L's hire date. On June 22, 2023, at 11:15 a.m., LALD-A and clinical nurse supervisor (CNS)-C stated CEC-L did not have the required training. LALD-A and CNS-C both stated this [lacking required dementia training] was a widespread issue. The licensee's Training and Competency of Unlicensed Staff policy revised January 16, 2023, noted staff who do not provide direct care, including maintenance, housekeeping, and food service staff, must have at least four hours of initial training on topics specified under paragraph (5B) within 160 working hours of the employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01550		
01750 SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the	01750		

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01750	Continued From page 16 proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) prepared in writing specific instructions for each resident and documented those instructions for one of five residents (R7). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R7's service plan dated May 26, 2021, authenticated July 19, 2021, included medication administration daily, morning and afternoon. R7's provider's order dated November 4, 2022, included: Fluticasone-Salmeterol "Flutic/Salme Aer" (Advair Diskus- asthma: difficulty breathing, wheezing, shortness of breath, coughing, chest tightness) 250/50 milligrams (mg) twice daily, inhale one (1) puff into the lungs twice daily.	01750		

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01750	Continued From page 17 R7's medication administration record (MAR) dated June 1, 2023, through June 21, 2023, included: -Advair Diskus 250/50 mg (Fluticasone-Salmeterol). Inhale one (1) puff into the lungs twice daily for asthma unspecified. On June 21, 2023, at 7:40 a.m., the surveyor observed unlicensed personnel (ULP)-N prepare R7's morning oral medication and put them into a medication cup. ULP-N removed Advair Diskus inhaler and Artificial Tears (eye drops) from the medication cart. ULP-N gave R7 the Advair inhaler and R7 took one (1) puff. ULP-N gave R7 the oral medications and R7 swallowed the medication with water. ULP-N administered R7's eye drops. The surveyor did not observe ULP-N instruct R7 to rinse mouth after inhaling Advair. Directly following the above observation ULP-N stated she did not know R7 should rinse her mouth after Advair inhaling. ULP-N added "some residents like it certain ways." On June 21, 2023, at 3:29 p.m., clinical nurse supervisor (CNS)-C confirmed R7's MAR did not include specific instructions for Advair inhaler. CNS-C stated his expectation was to have specific instructions printed on the MAR. The manufacturer's direction for Advair Diskus inhaler dated December 2021, noted rinse your mouth with water without swallowing after using Advair to help reduce your chance of getting thrush. The licensee's Delegation of Nursing, Treatment or Therapy Tasks policy revised January 16, 2023, noted prior to delegation medication administration only after the registered nurse	01750		

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01750	Continued From page 18 developed specific written instructions for each client and documented those instructions in the resident's medication record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01880 SS=E	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 medication was secured in a locked area for four of seven residents, (R2, R5, R3, R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R2 On June 21, 2023, at 7:37 a.m., the surveyor observed unlicensed personnel (ULP)-D administer R2's morning oral medication. The	01880		

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01880	Continued From page 19 surveyor observed one unopened box of Clear Eyes (dry eye solution) and one bottle of Clear Eyes out of the box sitting on R2's bedside table. R2's service plan dated January 1, 2021, included medication administration, and central storage of medication. R2's medication management plan dated October 13, 2022, noted R2 received medication administration and R2's medications would be stored outside resident's home in locked container. "Medications will be stored in the locked medication cart with access limited to nurses and RAs (resident assistance/ULP). Overflow medication will be stored in the locked medication room with access limited to nurses." R5 On June 21, 2023, at 7:58 a.m., the surveyor observed ULP-E administer R5's morning oral medication. The surveyor observed an opened container of Omega 3 gummy vitamins on a stand near a chair in R5's room. R5's service plan dated November 25, 2020, included medication administration, and central storage of medication. R5's medication management plan dated January 17, 2023, noted R5 received medication administration. "Medications will be stored in the locked medication cart with access limited to nurses and RAs. Overflow medication will be stored in the locked medication room with access limited to nurses." In addition, resident would keep limited number of medications in her room and self-administer, her family had requested that resident be allowed to keep a supply of ASA (aspirin) 81 milligrams (mg) in her room and	01880		

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01880	Continued From page 20 self-administer for chest pain. PCP (primary care provider) aware. R3 On June 21, 2023, at 8:18 a.m., the surveyor observed ULP-D administer R3's oral medication, eye drops, check R3's blood glucose and apply a compression stocking to R3's left leg. The surveyor observed an open bottle of nasal spray (normal saline) on table in R3's room. The bottle appeared to have been used. ULP-D commented "I don't know what that [nasal spray]" is. R3 stated she had not needed it [nasal spray] "much" this year. R3's service plan dated February 19, 2019, included medication administration, and central storage of medication. R3's medication self-administration assessment dated May 9, 2023, noted resident was appropriate to store artificial tears (lubricating eye drops), calmoseptine (treat/prevent minor skin irritations), and Eucerin lotion (moisturizer to treat or prevent dry, rough, scaly, itchy skin and minor skin irritations) in her room and self-administer. R6 On June 21, 2023, at 9:50 a.m., the surveyor observed ULP-J administer R9's morning oral medications. The surveyor observed a tube of Aspercreme (topical pain relief cream), opened on a side table in R9's room R6's service plan dated December 1, 2020, included medication administration and medication central storage. R6's medication management plan dated May 22, 2023, noted R9 received medication	01880		

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01880	Continued From page 21 administration and R9's medications would be stored outside client's home in locked container. "Medications will be stored in the locked medication cart with access limited to nurses and RAs. Overflow medication will be stored in the locked medication room with access limited to nurses." On June 21,2023, at 12:50 p.m., regional director of operation (RDO)-B stated he would "imagine" an order was needed for R6's Aspercreme. On June 21, 2023, at 3:35 p.m., clinical nurse supervisor (CNS)-C and registered nurse (RN)-G stated they were unaware of the Omega 3 gummy vitamins in R5's room. RN-G stated R5 was "ok'ed" to have ASA 81 mg at bedside adding R5's ASA 81 mg just got discontinued. CNS-C and RN-G stated they were unaware of the eye drops in R2's room and the Aspercreme in R6's room. CNS-C stated he "thought" R3 had an assessment to keep medications in her room. The assessment was reviewed with CNS-C and CNS-C stated nasal spray was not included on the assessment. The licensee's Storage of Medications policy revised January 16, 2023, noted a registered nurse must conduct a nursing assessment of a client's (resident) request for medication management services, including the appropriate way to store the client's medications and whether secured storage is appropriate given the client's functional and cognitive status, concerns about the potential for drug diversion or other considerations. When secured storage of the medications is necessary, the RN would identify where the medications would be stored, how they would be secured or locked under proper temperature controls and who had access to the	01880		

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01880	Continued From page 22 medications. 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 ensure medications were maintained bearing the original prescription label with legible information including the expiration date for time sensitive medications for one of three 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) 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 June 20, 2023, at 1:20 p.m., the surveyor observed the licensee's medication storage	01890		

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01890	Continued From page 23 system in the secured unit, on the main floor of the facility. R9's - opened Levemir (long-acting insulin) 100 unit/milliliter (ml) insulin pen lacked the date the pen had been opened and when the pen would expire - opened Novolog (short acting insulin) 100 units/ml insulin insulin pen lacked the date the pen had been opened and when the pen would expire. On June 20, 2023, at 1:33 p.m., unlicensed personnel (ULP)-H stated staff who administered medications to residents in the facility were trained to write the date when a medication with a shortened expiration date was opened on the medication label. ULP-H stated the date when opened was not applied to either of the above listed medications for R9. On June 20, 2023, at 1:54 p.m., licensed practical nurse, (LPN)-O stated ULPs were educated on the guidelines of time-sensitive medications once opened and were expected to abide by these guidelines. On June 22, 2023, at 10:45 a.m., licensed assisted living director (LALD)-A stated nursing was in charge of the medication management, administration and storage in the facility. LALD-A explained that although staff was trained to refer to the manufacturer's guidelines for time-sensitive medications, it was ultimately the registered nurse's responsibility to ensure the efficacy and storage of these medications which included insulin. The Carefree Living Policy Storage of	01890		

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01890	Continued From page 24 Medications 2.01 revised January 1, 2023, directed staff to store insulin per manufacturer guidelines. -Novolin 70/30 FlexPen's manufacturer's instructions updated November 2022, indicated the FlexPen should be discarded 28 days after opening, even if the FlexPen has insulin remaining. -Levemir FlexTouch Pen manufacturer's guidelines revised January 2019, indicated the FlexTouch Pen should be thrown out 42 days, even if it still has insulin left in it. The licensee's Medication Exp (expiration) sheet, printed March 3, 2023, directed staff to discard insulin pens as follows: -Levemir FlexPen, 42 days after opening -Novolog FlexPen Apart, 28 days after opening No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01950 SS=F	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has:	01950		

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01950	Continued From page 25 (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure prior to delegating nursing tasks, the registered nurse (RN) trained and had unlicensed personnel (ULP) demonstrate the ability to follow the procedure to perform the tasks using the FreeStyle blood glucose (sugar) monitoring system (system that measures glucose levels through a small sensor, the size of two stacked quarters, applied to the back of the upper arm), for one of one resident (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: R3's diagnosis include diabetes mellitus with diabetic nephropathy (deterioration of kidney function) On June 21, 2023, at 8:18 a.m., the surveyor observed ULP-D hold a FreeSyle blood glucose	01950		

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BURNSVILLE CAREFREE LIVING	600 EAST NICOLLET BOULEVARD BURNSVILLE, MN 55337

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01950	Continued From page 26 meter to the back on R3's right arm and state the reading was 214 as ULP-D showed the numbers on the meter to R3. R3's service plan dated April 26, 2021, included blood sugar checks 8:00 a.m., 12:00 p.m., 5:00 p.m., and 8:00 p.m. R3's provider's orders dated December 12, 2022, included blood sugar checks four times a day: -check blood sugars before meals and at HS (hour of sleep). Update nurse if less than 70 or greater than 400. Resident keep meter in her room 8:00 a.m., 12:00 p.m., 4:00 p.m., and 8:00 p.m., for diabetes: -FreeSyle Libre sensor (continuous blood glucose sensor, use as directed every 14 days with Libre 2 reader, as needed (PRN) -Freestyle reader (continuous blood glucose receiver) use with Libre 2 sensors -FreeSyle reader (continuous blood glucose receiver) use with Libre 2 sensors, PRN for diabetes with diabetic nephropathy. R3's medication administration record (MAR) dated June 1, 2023, through June 20, 2023, included: -blood sugar checks, check blood sugar before meals and at HS (bedtime). Update nurse if less than 70 or greater than 400. Resident has Freestyle Libre Monitor. On June 21, 2023, at 12:13 p.m., regional director of operation (RDO)-B and RN-G said ULP-D had not been trained and demonstrated competency for the FreeSyle blood monitoring system. In addition, RDO-B and RN-G stated the RN had not done training for any of the ULPs for this task. The licensee's Delegation of Nursing, Treatment	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20191	A. BUILDING: _____ B. WING _____	06/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BURNSVILLE CAREFREE LIVING	600 EAST NICOLLET BOULEVARD BURNSVILLE, MN 55337

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01950	Continued From page 27 or Therapy Tasks policy revised January 16, 2023, noted when the registered nurse delegated tasks to unlicensed personnel, that person must ensure that prior to the delegation the unlicensed personnel was trained in the proper methods to perform the tasks or procedures for each resident and is able to demonstrate that ability to competently follow the procedures and perform the tasks. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide a hazard vulnerability assessment or safety risk assessment of the physical environment on and around the property. This deficient practice had the ability to affect all staff, residents, and visitors.	02040		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20191	A. BUILDING: _____ B. WING _____	06/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BURNSVILLE CAREFREE LIVING	600 EAST NICOLLET BOULEVARD BURNSVILLE, MN 55337

(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
02040	Continued From page 28 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A record review of available documentation and interview were conducted June 21, 2023, at approximately 10:30 a.m. with licensed assisted living director (LALD)-A on the hazard vulnerability assessment for the physical environment of the facility. Record review of the available documentation indicated that the licensee had not performed a hazard vulnerability assessment with mitigation factors on and around the property. This deficient condition was verified by LALD-A during the interview at approximately 1:00 p.m. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	02040		

Minnesota Department of Health
Environmental Health, FPLS
P.O Box 64975
Saint Paul
651-201-4500

Type: Full
Date: *06/21/23*
Time: 12:59:42
Report: 1018231100

Food and Beverage Establishment Inspection Report

Location:
Burnsville Carefree Living
600 East Nicollet Boulevard
Burnsville, MN55337
Dakota County, 19

Establishment Info:
ID #: 0038211
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9528925559
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.

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Quaternary Ammonia: = 400PPM at Degrees Fahrenheit
Location: 3 COMPARTMENT SINK
Violation Issued: No

Chlorine: = 100PPM at Degrees Fahrenheit
Location: DISHWASHER
Violation Issued: No

Food and Equipment Temperatures

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

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

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

Process/Item: Cold Holding/ LETTUCE
Temperature: 38 Degrees Fahrenheit - Location: WALK IN COOLER
Violation Issued: No

Process/Item: Cold Holding/ CHICKEN
Temperature: 39 Degrees Fahrenheit - Location: WALK IN COOLER
Violation Issued: No

Type: Full
Date: *06/21/23*
Time: 12:59:42
Report: 1018231100
Burnsville Carefree Living

Food and Beverage Establishment Inspection Report

Process/Item: Cold Holding/ MILK
Temperature: 40 Degrees Fahrenheit - Location: MEMORY CARE KITCHEN COOLER
Violation Issued: No

Process/Item: Hot Holding/ SOUP
Temperature: 183 Degrees Fahrenheit - Location: WARMER
Violation Issued: No

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

INSPECTION CONDUCTED WITH CYNDI CASEY (MDH) PRESENT

ESTABLISHMENT USES ALL PASTEURIZED EGGS.

DISCUSSED EMPLOYEE ILLNESS, COOLING PROCEDURES, DATE MARKING AND PEST CONTROL.

ESTABLISHMENT HAS ONE MAIN KITCHEN AND ONE SATELLITE KITCHEN IN THE MEMORY CARE UNIT.

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 1018231100 of 06/21/23.

Certified Food Protection Manager: MICHELLE LYN GUSTAFSON

Certification Number: FM63255 Expires: 10/03/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
Establishment Representative

Signed: _____
Rebecca Prestwood
Sanitarian 3
6512013777
rebecca.prestwood@state.mn.us