Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

October 2, 2023

Licensee
Minnesota Senior Living DBA The Rivers
11111 River Hills Drive
Burnsville, MN 55337

RE: Project Number(s) SL21779015

Dear Licensee:

On September 15, 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 December 19, 2022. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the December 19, 2022 survey.

The Department of Health concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on December 19, 2022, found not corrected at the time of the September 15, 2023, follow-up survey and/or subject to penalty assessment are as follows:

1470 - Content Of Required Orientation - 144g.63 Subd. 2
1500 - Required Annual Training - 144g.63 Subd. 5
1910 - Disposition Of Medications - 144g.71 Subd. 22

The details of the violations noted at the time of this follow-up survey completed on September 15, 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 based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

Also, at the time of this follow-up survey completed on September 15, 2023, we identified the following violation(s):

1530 - Training In Dementia Care Required - 144g.64

The details of the violation(s) noted at the time of this follow-up survey are delineated on the attached State Form. Only the ID Prefix Tag in the left hand column without brackets will identify these state

correction orders. It is not necessary to develop a plan of correction.

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

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).

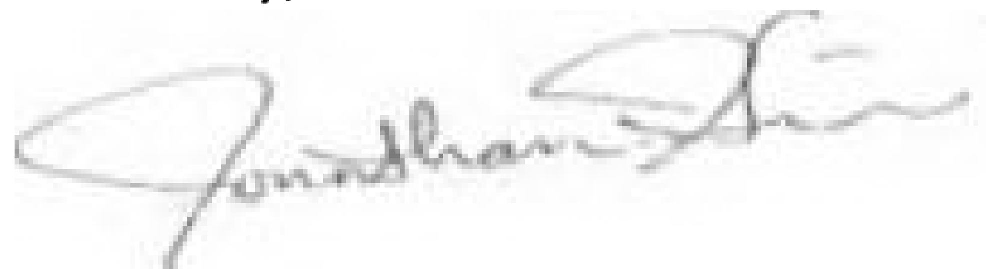
Please address your cover letter for reconsideration requests to:

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 Jonathan Hill at 651-201-3993.

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,



Jonathan Hill, Supervisor
State Evaluation Team
Email: jonathan.hill@state.mn.us
Telephone: 651-201-3993 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
	21779	A. BUILDING: ____ B. WING ____	R 09/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINNESOTA SENIOR LIVING DBA TH	11111 RIVER HILLS DRIVE 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: SL21779015-1 On September 13, through September 15, 2023, the Minnesota Department of Health conducted a desk review at the above provider to follow-up on orders issued pursuant to a survey completed on December 19, 2022. At the time of the survey, there were 77 receiving services under the Assisted Living with Dementia Care license. As a result of the revisit, the following orders were issued and 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.	
{01470} SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics:	{01470}		

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{01470}	Continued From page 1 (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation 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:	{01470}		

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{01470}	Continued From page 2	{01470}		

(1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication;
(2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or
(3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to ensure employees received orientation to include all required content for two of four employees (unlicensed personnel (ULP)-L, licensed practical nurse (LPN)-I).

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:

ULP-L
ULP-L was hired May 19, 2020, under the licensee's comprehensive license, and began providing assisted living services August 1, 2021.

ULP-L's employee record lacked documentation ULP-L completed required assisted living

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{01470}	Continued From page 3	{01470}		

orientation content before providing assisted living services to residents, including:
-an overview of Assisted Living laws, 144G;
-review of provider's policies and procedures;
-handling emergencies and using emergency services;
-reporting maltreatment of vulnerable adults or minors;
-Assisted Living Bill of Rights;
-handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints;
-the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; and
-a review of the types of assisted living services the employee would be providing and the provider's scope of license.

LPN-I
LPN-I was hired June 8, 2022, and provided direct care services to residents.

LPN-I's employee record lacked documentation LPN-I completed required assisted living orientation content before providing assisted living services to residents, including:
-review of provider's policies and procedures;
-handling emergencies and using emergency services;
-reporting maltreatment of vulnerable adults or minors;
-handing of resident complaints, reporting of complaints, where to report; and
-principles of person-centered planning/service delivery.

The licensee provided documented corrective

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{01470}	Continued From page 4 actions, in response to the correction order, which was previously issued on a survey ending December 19, 2022. The documentation indicated, "Audits of all direct care employees are being completed to ensure required training and competency evaluations are completed." The documentation further indicated, "ED, Director of Nursing and BOM [business office manager] are responsible for compliance", and and indicated the correction was completed January 6, 2023. On September 15, 2023, at 9:09 a.m., director of clinical services (DCS)-B stated, via email, the online training system was set-up to auto-populate the required new hire orientation. DCS-B further stated the orientation was managed by the Business Office Manager and human resources (HR). DCS-B did not comment as to why LPN-I and ULP-L lacked the required orientation. The licensee's Orientation for Assisted Living Staff policy, revised December 26, 2022, indicated, "All assisted living employees must complete an orientation to assisted living facility licensing requirements and regulations before providing services to residents." No further information was provided.	{01470}		
{01500} SS=D	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 5 (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 6	{01500}		

age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or
(3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to ensure employees received at least eight hours of annual training for each 12 months of employment for one of three employees (unlicensed personnel (ULP)-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 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-L was hired May 19, 2020, and provided direct care services for residents.

ULP-L's employee record included a training transcript that indicated on March 14, 2023, ULP-L received training on the Assisted Living Bill of Rights and "Abuse Prevention". The record lacked documentation of eight hours of annual training completed within the previous 12 months, including:

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{01500}	Continued From page 7	{01500}		

-review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases;

-effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders;

-review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and

-the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person.

The licensee provided documented corrective actions, in response to the correction order, which was previously issued on a survey ending December 19, 2022. The documentation indicated, "Audits of all direct care employees are being completed to ensure required 8 hours of annual training for each 12 months of employment, including 2 hours of dementia training." The documentation further indicated, "ED, Director of Nursing and BOM are responsible for compliance", and indicated the correction was completed January 9, 2023.

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{01500}	Continued From page 8	{01500}		

On September 15, 2023, at 9:09 a.m., director of clinical services (DCS)-B stated, via email, that starting this year, she took over the responsibility of assigning the annual education for employees. DCS-B did not comment as to why ULP-L was lacking annual training.

The licensee's Required Annual Staff Training policy, revised December 26, 2022, indicated, "1. All assisted living employees will complete annual education on the following topics:
a. Reporting of maltreatment of vulnerable adults under section 626.557
b. Assisted living bill or rights
c. Staff responsibility related to ensuring the exercise and protection in the assisted living bill of rights
d. Infection control techniques used in the home and implementation of infection control standards including
i. Hand washing
ii. Need for and use of protective gloves, gowns, and masks
iii. Appropriate disposal of contaminated materials and equipment such as dressings, needles, syringes, and razor blades
iv. Disinfecting reusable equipment
v. Disinfecting environmental surfaces
vi. Reporting communicable diseases
e. Effective approaches for problem solving when working with challenging behaviors
f. Effective approaches for communication with residents with dementia, Alzheimer's disease or related disorders
g. Review of policies and procedures relating to the provision o assisted living services and how to implement them
h. Principles of person-centered planning and service delivery

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{01500}	Continued From page 9	{01500}		

i. How person-centered planning and service delivery applies to direct support services provided by staff
j. Emergency and disaster training

No further information was provided.

01530 SS=D | 01530

144G.64 TRAINING IN DEMENTIA CARE REQUIRED

(a) All assisted living facilities must meet the following training requirements:
(1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 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;
(2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter;

This MN Requirement is not met as evidenced by:

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01530	Continued From page 10	01530		

Based on interview, and record review, the licensee failed to ensure the required amount of dementia care training was completed in the required time frame in accordance with 144G.64 for one of three employees (unlicensed personnel (ULP)-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) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).

The findings include:

The licensee had a current assisted living facility with dementia care (ALFDC) license.

ULP-L was hired May 19, 2020, and provided direct care services for residents.

ULP-L's employee record lacked documentation of two hours of dementia care training completed within the previous 12 months.

On September 15, 2023, at 9:09 a.m., director of clinical services (DCS)-B stated, via email, that starting this year, she took over the responsibility of assigning the annual education for employees. DCS-B did not comment as to why ULP-L was lacking annual dementia care training.

The licensee's Dementia Training policy, dated December 26, 2022, indicated, "Assisted living staff will receive required training on dementia care during orientation and annually."

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01530 Continued From page 11 — 01530

No further information was provided.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days

{01910} SS=D — 144G.71 Subd. 22 Disposition of medications — {01910}

(a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal.
(b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances.
(c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to provide documentation in the resident's record regarding the disposition of medications to include quantity of medications, for two of two discharged residents (R7, R8).

This practice resulted in a level two violation (a violation that did not harm a resident's health or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21779	A. BUILDING: ______ B. WING ______	R 09/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINNESOTA SENIOR LIVING DBA TH	11111 RIVER HILLS DRIVE 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
{01910}	Continued From page 12	{01910}		

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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
R7's service plan, dated July 10, 2023, indicated R7 received services including assistance with medication management.

R7's record included a medication disposition form, signed by director of nursing (DON)-E July 17, 2023. The disposition form indicated medications were destroyed, including:
-zofran tablet 4 milligrams (mg);
-metoprolol tartrate 50 mg;
-diltiazem 24 hour, extended release 180 mg;
-omeprazole capsule delayed release 20 mg;
-phenytoin sodium extended release 100 mg;
-pyridoxine hydrochloride (HCL) tablet 25 mg;
-atorvastatin calcium oral tablet 20 mg;
-apixaban oral tablet 5 mg; and
-folic acid 1 mg tablet.
The disposition form lacked documentation of the quantity of each medication destroyed.

R8
R8's service plan, dated March 27, 2023, indicated R8 received services including assistance with medication management.

R8's record included a medication disposition form, signed by DON-E July 3, 2023. The disposition form indicated R8 was discharged to "home/other facility". The form further indicated

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	21779	A. BUILDING: ______ B. WING ______	R 09/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINNESOTA SENIOR LIVING DBA TH	11111 RIVER HILLS DRIVE BURNSVILLE, MN 55337

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{01910}	Continued From page 13	{01910}		

Continued From page 13

medications were sent with R8 to "receiving facility/home", including:
-gabapentin capsule 100 mg;
-loperamide HCl tablet 2 mg;
-tylenol oral tablet 1000 mg;
-vitamin C oral tablet 500 mg;
-FerrouSul oral tablet 325 mg;
-guaifenesin oral tablet 400 mg;
-cetirizine HCl oral Tablet 5 mg;
The disposition form identified the person who received the medications, but lacked documentation of the quantity of each medication.

The licensee provided documented corrective actions, in response to the correction order, which was previously issued on a survey ending December 19, 2022. The documentation indicated, "A Discharge/Disposition check-off-lists and audits system have been put in place to ensure documentation regarding the disposition of medications for discharged residents is done per policy and procedure. Director of Nursing or their designee is responsible for compliance." The documentation lacked a completion date for the correction.

On September 14, 2023, at 11:14 a.m., director of clinical services (DCS)-B stated via email that the counts section of the medication disposition records were not completed.
-at 12:38 p.m., DCS-B stated via email, the missing information was an oversight of DON-E, and that she was focused on getting the medication sent out. DCS-B further stated the counts would be completed moving forward.

The licensee's Disposal of Medication policy, revised December 26, 2022, indicated, "Current unused medications managed by the home care provider will be returned to the pharmacy for

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MINNESOTA SENIOR LIVING DBA TH	11111 RIVER HILLS DRIVE BURNSVILLE, MN 55337

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{01910}	Continued From page 14 credit, or given to the resident or the resident ' s representative, when the resident's medications are no longer managed by the home care provider or the medication has been discontinued by the prescriber. Upon disposition, the home care provider must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition." No further information was provided.	{01910}		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

December 29, 2022

Licensee
Minnesota Senior Living DBA The Rivers
11111 River Hills Drive
Burnsville, MN 55337

RE: Project Number(s) SL21779015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on December 19, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

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

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

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

St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services = $3,000

The total amount you are assessed is $3,000. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

Please address your cover letter for general | Free from Maltreatment reconsideration

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

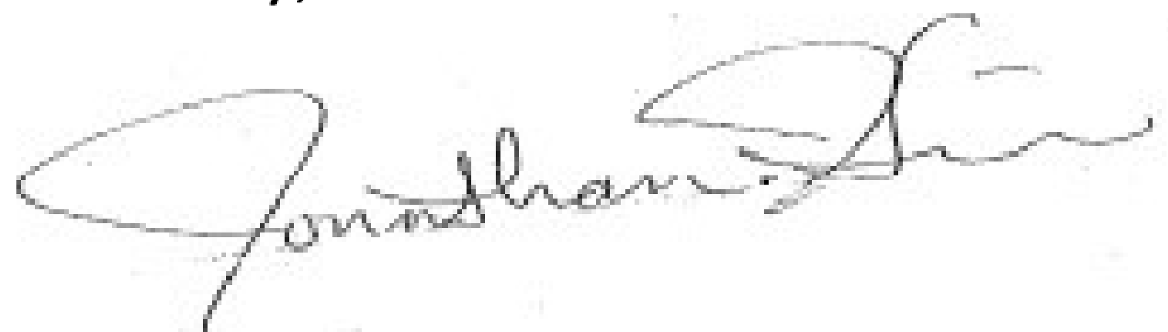
requests should be addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

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

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

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

Sincerely,



Jonathan Hill, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-3993 Fax: 651-215-9697

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21779	A. BUILDING: ______ B. WING ______	12/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINNESOTA SENIOR LIVING DBA TH	11111 RIVER HILLS DRIVE 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 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: SL21779015 On December 12 through December 19, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 72 residents receiving services under the provider's Assisted Living with Dementia Care license. On December 13, 2022, at approximately 12:40 p.m., an immediate correction order was issued for 2310. On December 13, 2022, at 2:00 p.m., the immediacy of correction order 2310 was removed, the scope and level of noncompliance remained the same.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living with Dementia Care 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.	
01470 SS=D	144G.63 Subd. 2 Content of required orientation	01470		

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01470	Continued From page 1 (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation 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	01470		

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MINNESOTA SENIOR LIVING DBA TH	**11111 RIVER HILLS DRIVE BURNSVILLE, MN 55337**

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01470	Continued From page 2	01470		

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 the challenges it poses to communication;
(2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or
(3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions.

This MN Requirement is not met as evidenced by:
Based on observation, interview and record review, the licensee failed to ensure employees received orientation to include all required content for one of two employees (unlicensed personnel (ULP)-F).

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:

ULP-F was hired November 29, 2022, and provided direct cares for residents of the facility.

On December 13, 2022, at 7:31 a.m., ULP-F was

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01470	Continued From page 3	01470		

observed to assist R5 with activities of daily living (ADL's).

ULP-F's employee record lacked documentation the following orientation topics were completed:
-Compliance with and reporting the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC);
-Handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints;
-Review of the principles of person-centered planning and service delivery.

On December 14, 2022, at 10:12 a.m., corporate director of clinical services (DCS)-B stated via e-mail ULP-F did not complete all orientation topics. DCS-B further stated the required orientation topics were assigned to ULP-F November 28, 2022.
-at 11:15 a.m. DCS-B stated it was the licensee's policy for caregivers to complete orientation prior to working directly with residents.

The licensee's Orientation for Assisted Living Staff policy, revised August 1, 2021, indicated, "All assisted living employees must complete an orientation to assisted living facility licensing requirements and regulations before providing services to residents."

No further information was provided.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days

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01500	Continued From page 4	01500		
01500 SS=D	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 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	01500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01500	Continued From page 5	01500		

Continued From page 5

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 interview and record review, the licensee failed to ensure employees received at least eight hours of annual training for each 12 months of employment for one of two employees (director of nursing (DON)-E).

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:

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01500	Continued From page 6 DON-E had a hire date of June 14, 2021. DON-E's employee record lacked evidence of eight hours of annual training. DON-E's employee training records lacked evidence DON-E had successfully completed annual training as required in the following areas: -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; -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. During interview on December 13, 2021, at approximately 2:00 p.m., assistant director (AD)-A confirmed DON-E's employee record lacked documentation of annual training. The licensee's Required Annual Staff Training policy dated August 1, 2021, verified the above required annual training. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		
01620 SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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MINNESOTA SENIOR LIVING DBA TH	**11111 RIVER HILLS DRIVE BURNSVILLE, MN 55337**

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01620	Continued From page 7 (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 a registered nurse (RN) conducted ongoing resident monitoring and reassessment 14 calendar days from the initial assessment, and not to exceed 90 calendar days from the previous assessment for two of five residents (R3, R5). 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 pattern scope (when more than a limited number	01620		

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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).

R3
R3's record lacked monitoring and reassessment not to exceed 90 days from the previous assessment.

R3's service plan, dated January 21, 2022, indicated R3 received services including assistance with blood glucose management, medication administration, housekeeping, and laundry.

R3's record included an assessment completed May 6, 2022, and a subsequent assessment completed August 12, 2022, 98 days after the previous assessment.

R5
R5's service plan, dated November 25, 2022, indicated R5 received services including assistance with medication management, housekeeping, laundry, assistance with dressing, and assistance with bathing.

R5's record included an initial assessment completed November 8, 2022. The record lacked a reassessment completed within 14 days after start of services.

On December 13, 2022, at 3:36 p.m., corporate director of clinical services (DCS)-B indicated R3's 90-day assessment may have been completed late due to staff being busy. DCS-B stated a notification is displayed in the electronic record 5 days prior to the assessment due date. DCS-B further stated the 14-day assessment for

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01620	Continued From page 9 R5 was not scheduled in the system, so was missed. The licensee's Nursing Assessment policy, dated August 1, 2021, indicated, "The 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." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an	01650		

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emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and
(iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to ensure the resident service plan included the required content for five of five residents (R1, R2, R3, R4, R5).

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

The findings include:

R1's service agreement, signed December 1, 2022, indicated R1 received services including assistance with medication management, safety checks, housekeeping, and laundry.

R2's unsigned service agreement, dated December 13, 2022, indicated R2 received services including assistance with medication management, application and removal of compression stockings, housekeeping, and laundry.

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R4's service agreement, signed June 3, 2022, indicated R4 received services including assistance with medication management, housekeeping, and laundry.

R5's service agreement, signed November 25, 2022, indicated R5 received services including assistance with medication management, housekeeping, laundry, dressing, and bathing.

R1, R2, R4, and R5's service agreements lacked the following:
-the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences;
-the identification of staff or categories of staff who will provide the services;
-the schedule and methods of monitoring assessments of the resident;
-the schedule and methods of monitoring staff providing services; and
-a contingency plan that includes:
(i) the action to be taken if the scheduled service cannot be provided;
(ii) information and a method to contact the facility;
(iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and
(iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters.

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R3's service agreement, signed January 20, 2022, indicated R3 received services including assistance with blood glucose monitoring, medication management, housekeeping, and laundry.

R3's service agreement lacked the following:
-the fees for services;
-the schedule and methods of monitoring assessments of the resident;
-the schedule and methods of monitoring staff providing services; and
-a contingency plan that includes:
(i) the action to be taken if the scheduled service cannot be provided;
(ii) information and a method to contact the facility;
(iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and
(iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters.

On December 13, 2022, at 8:27 a.m. director of clinical services (DCS)-B stated the director of nursing printed the abbreviated service plan, which indicated only the services provided, for the resident to sign. DCS-B stated the paperwork to sign can be overwhelming, and the single page format was less confusing for the resident.

The licensee's Service Plans policy, revised August 1, 2021, indicated, "The service plan and

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01650	Continued From page 13 any revisions must include a signature or other authentication by the home care provider and by the resident or the resident's representative documenting agreement on the services to be provided." The policy further indicated the service plan must include, "1. A description of the home care services to be provided, the fees for services (including any changes to the provider's fee for services), and the frequency of each service, according to the resident's current review or assessment and resident preferences. 2. The identification of the type staff (RN/LPN, Therapists, Unlicensed Personnel, etc.) that will provide the services. 3. The schedule and methods of monitoring reviews or assessments of the resident. 4. The frequency of sessions of supervision of staff and type of personnel who will supervise staff. 5. A contingency plan that includes: a. the action to be taken by the home care provider and by the resident or resident's representative if the scheduled service cannot be provided; b. information and method for a resident or resident's representative to contact the home care provider; c. names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and d. the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters.	01650		

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01650	Continued From page 14 6. Information regarding how to contact the Minnesota Office of the Ombudsman for Long-Term Care." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01650		
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 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 and manufacturer recommendations for one of three residents observed for medication administration (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	01760		

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01760	Continued From page 15	01760		

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:

R3's service plan, dated January 20, 2022, indicated R3 received services including assistance with blood glucose monitoring and medication management.

R3's record included prescriber orders signed September 20, 2022, indicating R3 was prescribed Novolog Flexpen insulin to be administered three times daily, at 8:00 a.m., 11:30 a.m., and 4:30 p.m.

R3's medication administration record (MAR) for December 2022 indicated R3 was assisted with insulin administration three times daily, at 8:00 a.m., 12:00 p.m., and 4:00 p.m.

On December 13, 2022, at 9:22 a.m., licensed practical nurse (LPN)-I was observed to administer medications to R3, including Novalog (insulin aspart-a fast-acting insulin). Prior to administering R3's scheduled insulin dose, LPN-I failed to prime the insulin pen by injecting 2 units into the waste receptacle. LPN-I indicated he would not typically prime that type of multi-dose insulin pen. LPN-I stated, "There's not really a way to prime them that I know of."

On December 13, 2022, at 10:07 a.m., director of clinical services (DCS)-B stated it was the licensee's policy to prime multi-dose insulin pens prior to each insulin administration.

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01760	Continued From page 16 Manufacturer instructions, revised March 2021, indicated before each injection with the Novolog Flexpen insulin pen, "To avoid injecting air and to ensure proper dosing", the user perform an "air shot" by turning the dose knob to two (2) units, holding the pen vertical with the needle pointing up, and pushing the dose knob until it stops. The instructions indicated if a droplet of medication is not visible at the tip of the needle, the needle be changed, and the action repeated, up to six times until a droplet of medication is visible at the tip of the needle. The licensee's Insulin policy, revised August 1, 2021, indicated, "Insulin medications must be administered according to the prescriber ' s orders." No further information provided TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances.	01910		

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(c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to provide documentation in the resident's record regarding the disposition of medications to include quantity and names of staff and other individuals involved in the disposition of medications, for one of one discharged resident (R6).

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).

The findings include:

R6's service plan, reviewed June 15, 2022, indicated R6 received assistance with medication management.

R6's discharge summary, dated July 27, 2022, indicated R6 was discharged July 27, 2022, to be closer to family.

R6's record included a Discontinued/Discharged Medications Disposition form, dated July 27,

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01910	Continued From page 18 2022. The form indicated medications were sent with the resident to the receiving facility, but lacked documentation of the name of the medications, strength, prescription number if applicable, and quantity. On December 12, 2022, at 1:41 p.m., licensed practical nurse and resident care manager (LPN)-G stated all discharge documentation was in the electronic record, and nothing would be kept on paper. LPN-G stated when resident is discharged, the family had choice to either have medications destroyed or to take them. LPN-G stated if the medications were destroyed, they would document it on the medication disposition form. On December 12, 2022, at 2:34 p.m., director of clinical services (DCS)-B stated there was no detailed disposition of medications for R6. DCS-B stated it was likely that information was sent along with the resident and they did not keep a copy for their records. The licensee's Disposal of Medication policy, updated August 1, 2021, indicated, "Current unused medications managed by the home care provider will be returned to the pharmacy for credit, or given to the resident or the resident ' s representative, when the resident's medications are no longer managed by the home care provider or the medication has been discontinued by the prescriber. Upon disposition, the home care provider must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the	01910		

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disposition."

No further information was provided.

TIME PERIOD FOR CORRECTION: Seven (7) days

01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders	01970		

There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months.

This MN Requirement is not met as evidenced by:
Based on observation, interview, and record review, the licensee failed ensure up-to-date written or electronically recorded orders were maintained for one of five residents (R1) receiving treatments for records reviewed.

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:

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01970	Continued From page 20 R1's diagnosis included dementia. R1's "Visual/Bedside Individual Service Plan Report" dated December 1, 2022, identified R1 received assistance with cervical collar application and removal. R1's medical record lacked evidence of a written prescriber order for cervical collar application and removal. On December 13, 2022, at 1:15 p.m., R1 was observed in her apartment dressed for the day and wearing her cervical collar. On December 13, 2022, at 1:20 p.m., director of clinical services (DCS)-B stated the licensee obtained physician orders for all for treatments provided to the licensee's residents. An order for the cervical collar should have been requested and received for the cervical collar and included in the medical record for R1. The licensee's Medication Treatment & Therapy Management Services policy dated August 1, 2021, verified "the nurse will get a sign [sic] doctors order for the treatment and therapy services." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		
02170 SS=D	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In	02170		

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02170	Continued From page 21	02170		

addition, the evaluation must address the following:
(1) past and current interests;
(2) current abilities and skills;
(3) emotional and social needs and patterns;
(4) physical abilities and limitations;
(5) adaptations necessary for the resident to participate; and
(6) identification of activities for behavioral interventions.
(c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs.
(d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to:
(1) occupation or chore related tasks;
(2) scheduled and planned events such as entertainment or outings;
(3) spontaneous activities for enjoyment or those that may help defuse a behavior;
(4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music;
(5) spiritual, creative, and intellectual activities;
(6) sensory stimulation activities;
(7) physical activities that enhance or maintain a resident's ability to ambulate or move; and
(8) outdoor activities.

This MN Requirement is not met as evidenced by:
Based on interview and record review, licensee failed to conduct an individualized written activity evaluation for one of two residents (R2) who resided on the dementia care unit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21779	A. BUILDING: ______ B. WING ______	12/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINNESOTA SENIOR LIVING DBA TH	11111 RIVER HILLS DRIVE 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
02170	Continued From page 22	02170		

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).

The findings include:

The licensee had a current assisted living with dementia care license.

R2 had diagnosis including Alzheimer's disease. R2's services plan dated November 16, 2022, indicated services provided included assistance with activities of daily living and medication management.

R2's record lacked the development of an individualized activity plan and any evidence R2 was evaluated for activities according to the licensing rules of the facility to include the following:
- past and current interests
- current abilities and skills
-emotional and social needs and patterns
- physical abilities and limitations
- adaptations necessary for the resident to participate; and
- identification of activities for behavioral interventions

On December 13, 2022, at 11:15 a.m., director of clinical services (DCS)-B confirmed evaluations for activities and individual activity plans had not been completed for R2.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21779	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ___ B. WING ___	(X3) DATE SURVEY COMPLETED 12/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINNESOTA SENIOR LIVING DBA TH	**11111 RIVER HILLS DRIVE 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
02170	Continued From page 23 The licensee lacked policies to include the new Assisted Living Licensure requirements, that went into effect August 1, 2021. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02170		
02310 SS=H	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 one of two residents (R2) who utilized hospital bed with rails. This resulted in issuance of an immediate correction order on December 13, 2022, at approximately 12:40 p.m. 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 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	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21779	A. BUILDING: ______ B. WING ______	12/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINNESOTA SENIOR LIVING DBA TH	11111 RIVER HILLS DRIVE 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
02310	Continued From page 24	02310		

Continued From page 24

found to be pervasive).

The findings include:

On December 13, 2022, at 8:00 a.m., R2 was observed lying in a hospital bed with bilateral half bed rails on the upper sides.

R2 had diagnosis to include Alzheimer's disease. R2's services plan dated November 16, 2022, indicated services provided included assistance with activities of daily living and medication management.

On December 13, 2022, at 11:15 a.m., director of clinical services (DCS)-B stated the bed rails had not been assessed for safety with measurements by registered nurse (RN). DCS-B confirmed the record lacked evidence education was provided to R2 or resident's representative on the risks associated with bed rail use.

The Food and Drug Administration (FDA) "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's (resident'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 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 March 10, 2006, FDA Side Rail Entrapment Zones and Dimensional Recommendations indicated to reduce the risk of entrapment, zone

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21779	A. BUILDING: ____ B. WING ____	12/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINNESOTA SENIOR LIVING DBA TH	11111 RIVER HILLS DRIVE 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
02310	Continued From page 25	02310		

1 (within the rail) should not exceed 4 and 3/4 inches, zone 2 (under the rail, between rail supports or next to a single rail support) should not
exceed 4 and 3/4 inches, zone 3 (between the rail and the mattress), should not exceed 4 and 3/4 inches, and zone 4 (under the rail, at the
ends of the rail) should not exceed 2 and 3/8 inches or be greater than a 60 degree angle.

The licensee's Side rails policy dated August 1, 2021, indicated "nurse will conduct a quarterly safety function of the siderail or any other mechanical device and review the risk and benefit of the mechanical device. Staff will be train (sp) on hire, annually, and as needed on the function of the siderail or mechanical device." In addition, the siderail design is consistent with the FDA's 2006 recommended dimensional measurements to reduce entrapment."

No further information provided.

TIME PERIOD FOR CORRECTION: Immediate

The immediacy of correction order, tag identification 2310 was removed on December 13, 2022, at 2:00 p.m., scope and level of noncompliance remained the same.

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

Type: Full
Date: *12/12/22*
Time: 08:52:12
Report: 1018221197

Food and Beverage Establishment Inspection Report

Location:
Minnesota Senior Living Dba Th
11111 River Hills Drive
Burnsville, MN55337
Dakota County, 19

Establishment Info:
ID #: 0039033
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9528908553
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: = 200PPM at Degrees Fahrenheit
Location: BUCKET
Violation Issued: No

Hot Water: = at 160 Degrees Fahrenheit
Location: DISHWASHER
Violation Issued: No

Food and Equipment Temperatures

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

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

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

Process/Item: Cooking/ SOUP
Temperature: 191 Degrees Fahrenheit - Location:
Violation Issued: No

Food and Beverage Establishment Inspection Report

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

VIEWED ILLNESS LOG AND DISCUSSED ILLNESS POLICY.

ESTABLISHMENT DOES ALL SAME DAY SERVICE. NO COOLING.

NO EGGS COOKED WITHIN THE FACILITY EXCEPT FOR BAKED GOODS.

NO ORDER ISSUED.

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 1018221197 of 12/12/22.

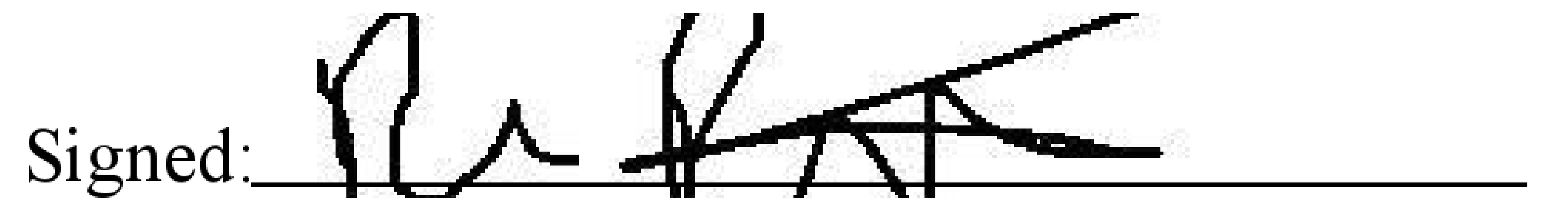
Certified Food Protection Manager: JASMINE L BOWE

Certification Number: FM64627 Expires: 05/11/24

Inspection report reviewed with person in charge and emailed.

Signed:_______________

JASMINE L BOWE
KITCHEN MANAGER

Signed: 

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