



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

August 20, 2025

Licensee

Arbor Park Living Center LLC

2921 6th Avenue North

Moorhead, MN 56560

RE: Project Number(s) SL30361016

Dear Licensee:

On June 24, 2025, 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 6, 2024. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the December 6, 2024 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 6, 2024, found not corrected at the time of the June 24, 2025, follow-up survey and/or subject to penalty assessment are as follows:

0780-Fire Protection And Physical Environment-144g.45 Subd. 2 (a) (1) - \$500.00

The details of the violations noted at the time of this follow-up survey completed on June 24, 2025 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Also, at the time of this follow-up survey completed on June 24, 2025, we identified the following violation(s):

0830-Local Laws Apply-144g.45 Subd. 3

The details of the violation(s) noted at the time of this follow-up are delineated on the attached State Form. Only the ID Prefix Tag in the left hand column without brackets will identify these state correction orders. It is not necessary to develop a plan of correction.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are**

assessed is \$500.00. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

IMPOSITION OF FINES

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

Level 2: a fine of \$500 per violation, 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 MDH within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

REQUESTING A HEARING

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

To submit a hearing request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration or a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

We urge you to review these orders carefully. If you have questions, please contact Benjamin J. Zwart at 651-201-3715.

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,

A handwritten signature in black ink that reads "Benjamin J. Zwart". The signature is written in a cursive style with a large, stylized 'B' and a long, sweeping underline.

Benjamin J. Zwart, Supervisor
State Engineering Services Section

Email: 651-201-3715

Telephone: 651-201-3715 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30361	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 06/24/2025
NAME OF PROVIDER OR SUPPLIER ARBOR PARK LIVING CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2921 6TH AVENUE NORTH MOORHEAD, MN 56560		
(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 FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SL#30361016-2 On June 25, 2025 through June 30, 2025, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on March 26, 2025. At the time of the survey, there were 44 residents; 44 receiving services under the Assisted Living Facility with Dementia Care license. As a result of the follow-up survey, the following orders were reissued, and a new order was issued.	{0 000}			
{0 100} SS=F	144G.10 Subdivision 1 License required (a)(1) Beginning August 1, 2021, no assisted living facility may operate in Minnesota unless it is licensed under this chapter. (2) No facility or building on a campus may provide assisted living services until obtaining the required license under paragraphs (c) to (e). (b) The licensee is legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. Nothing in this chapter shall in any way affect the rights and remedies available under other law. (c) Upon approving an application for an assisted living facility license, the commissioner shall issue a single license for each building that is operated by the licensee as an assisted living facility and is located at a separate address, except as provided under paragraph (d) or (e). If	{0 100}			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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{0 100}	Continued From page 1 a portion of a licensed assisted living facility building is utilized by an unlicensed entity or an entity with a license type not granted under this chapter, the licensed assisted living facility must ensure there is at least a vertical two-hour fire barrier as defined by the National Fire Protection Association Standard 101, Life Safety Code, between any licensed assisted living facility areas and unlicensed entity areas of the building and between the licensed assisted living facility areas and any licensed areas subject to another license type. (d) Upon approving an application for an assisted living facility license, the commissioner may issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility. An assisted living facility license for a campus must identify the address and licensed resident capacity of each building located on the campus in which assisted living services are provided. (e) Upon approving an application for an assisted living facility license, the commissioner may: (1) issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility with dementia care, provided the assisted living facility for dementia care license for a campus identifies the buildings operating as assisted living facilities with dementia care; or (2) issue a separate assisted living facility with dementia care license for a building that is on a campus and that is operating as an assisted living facility with dementia care. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 100}			

Minnesota Department of Health

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{0 480} SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A,	{0 480}			

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{0 480}	Continued From page 3 existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 480}			
{0 780} SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in	{0 780}			

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{0 780}	Continued From page 4 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 record review and interview, the licensee failed to comply with Minnesota State Fire Code Rules, Chapter 7511. 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 the potential to affect a large portion or all of the residents). The findings include: On June 25, 2025, at 12:10 p.m., the surveyor emailed licensed assisted living director (LALD)-A requesting documentation to support corrections for the 0780 tag pursuant to surveys completed on December 5, 2024, and March 27, 2025. On June 26, 2025, at 5:00 p.m., chief clinical officer (CCO)-J responded in an email we are currently working at collecting the data requested for the desk audit. Please see items attached:	{0 780}			

Minnesota Department of Health

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{0 780}	Continued From page 5 - Current resident roster. - Plan of correction, documentation, and photos. - Fire alarm system quote dated March 25, 2025. - Minnesota Department of Health Engineering Services plan submittal form and copy of a letter signed by environmental management explaining that a building permit from the local regulatory authority having jurisdiction was not required for the proposed fire panel project. CCO-J responded we will review the MDH plan approval letter and get the response to you no later than tomorrow by 5 p.m. We had to request a new one as we did not receive the initial letter. Construction has not been initiated, however, the approval letter has been sent to Summit to review and provide a date for project initiation. On June 27, 2025, at 1:15 p.m., CCO-J emailed the surveyor we did hear back from Summit who will be performing the fire panel project. They are out of the office but will respond to the approval letter Monday morning. I will get the responses to you as soon as I have them. Previous survey findings: On March 27, 2025, at 12:35 p.m., the surveyor emailed licensed assisted living director (LALD)-A requesting documentation to support corrections for the 0780 tag pursuant to a survey completed on December 5, 2024. On March 27, 2025, at 3:37 p.m., LALD-A emailed a proposed written plan from their system provider and indicated the the project would be completed upon plan approval from the State of Minnesota. Additionally, the licensee provided a plan of correction for violation tag number 780 tag, dated February 7, 2025.	{0 780}			

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{0 780}	Continued From page 6 During an interview on April 4, 2025, at 12:29 p.m., chief clinical officer (CCO)-J stated the plan review application for the 0780 tag correction project was submitted on March 27, 2025. CCO-J stated the company hired for the project would be scheduled to begin the work mid-late April.	{0 780}			
{0 790} SS=F	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 790}			
{0 800} SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program.	{0 800}			

Minnesota Department of Health

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{0 800}	Continued From page 7	{0 800}			
{0 810} SS=F	This MN Requirement is not met as evidenced by: Not reviewed during this survey. 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) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff 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 staff 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	{0 810}			

Minnesota Department of Health
STATE FORM 6899 N3L113 If continuation sheet 9 of 12

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30361	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 06/24/2025
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0 830	Continued From page 9 The findings include: On June 26, 2025, the licensee emailed the surveyor a plan of correction for the 0780 tag. The plan indicated an illuminated exit sign had been removed in the Pines building. On June 27, 2025, the surveyor emailed the licensee that removal of an illuminated exit sign would require plan review by Minnesota Department of Health engineering services and review by the local building and/or fire official. On June 30, 2025, the licensee responded in an email to the surveyor that they had directed this clarification to the maintenance manager and will provide a response as soon as possible. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 830			
{01880} SS=F	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: Not reviewed during this survey.	{01880}			
{01890} SS=F	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	{01890}			

Minnesota Department of Health

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{01890}	Continued From page 10 expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{01890}			
{02040} SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care must meet the requirements of section 144G.45 and the following additional requirements: (1) an assessment of safety risks must be performed on and around the property. The safety risks identified by the facility on the assessment must be mitigated to protect the residents from harm. The mitigation efforts must be documented in the facility's records; 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: Not reviewed during this survey.	{02040}			
{02310} SS=F	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	{02310}			

Minnesota Department of Health

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{02310}	Continued From page 11 by: Not reviewed during this survey.	{02310}			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

April 21, 2025

Licensee

Arbor Park Living Center LLC

2921 6th Avenue North

Moorhead, MN 56560

RE: Project Number(s) SL30361016

Dear Licensee:

On March 26, 2025, 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 6, 2024. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the December 6, 2024 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on December 6, 2024, found not corrected at the time of the March 26, 2025, follow-up survey and/or subject to penalty assessment are as follows:

0780 - Fire Protection And Physical Environment - 144g.45 Subd. 2 (a) (1) - \$500.00

1890 - Prescription Drugs - 144g.71 Subd. 20 - \$500.00

2310 - Appropriate Care And Services - 144g.91 Subd. 4 (a) - \$500.00

The details of the violations noted at the time of this follow-up survey completed on March 26, 2025 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$1,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

Also, at the time of this follow-up survey completed on March 26, 2025, we identified the following violation(s):

1880 - Storage Of Medications - 144g.71 Subd. 19

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 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 MDH within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

REQUESTING A HEARING

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

To submit a hearing request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

We urge you to review these orders carefully. If you have questions, please contact 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,

A handwritten signature in cursive script that reads "Jessie Chenze". The ink is dark and the signature is fluid.

Jessie Chenze, Supervisor

State Evaluation Team

Email: jessie.chenze@state.mn.us

Telephone: 218-332-5175 Fax: 1-866-890-9290

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30361	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 03/26/2025
NAME OF PROVIDER OR SUPPLIER ARBOR PARK LIVING CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2921 6TH AVENUE NORTH MOORHEAD, MN 56560		
(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 FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SL#30361016-1 On March 24, 2025 through March 26, 2025, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on December 6, 2024. At the time of the survey, there were 45 residents; 45 receiving services under the Assisted Living Facility with Dementia Care license. As a result of the follow-up survey, the following orders were reissued, and a new order was issued.	{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 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 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 evaluators ' 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 SUBDIVISION 1-3.		
{0 100} SS=F	144G.10 Subdivision 1 License required (a)(1)Beginning August 1, 2021, no assisted living	{0 100}			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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{0 100}	Continued From page 1 facility may operate in Minnesota unless it is licensed under this chapter. (2) No facility or building on a campus may provide assisted living services until obtaining the required license under paragraphs (c) to (e). (b)The licensee is legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. Nothing in this chapter shall in any way affect the rights and remedies available under other law. (c) Upon approving an application for an assisted living facility license, the commissioner shall issue a single license for each building that is operated by the licensee as an assisted living facility and is located at a separate address, except as provided under paragraph (d) or (e). (d) Upon approving an application for an assisted living facility license, the commissioner may issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility. An assisted living facility license for a campus must identify the address and licensed resident capacity of each building located on the campus in which assisted living services are provided. (e) Upon approving an application for an assisted living facility license, the commissioner may: (1) issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility with dementia care, provided the assisted living facility for dementia care license for a campus identifies the buildings operating as assisted living facilities with dementia care; or (2) issue a separate assisted living facility with dementia care license for a building that is on a campus and that is operating as an assisted living facility with dementia care.	{0 100}			

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{0 100}	Continued From page 2	{0 100}			
	This MN Requirement is not met as evidenced by:		Not reviewed during this survey.		
{0 480} SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage;	{0 480}			

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{0 480}	Continued From page 3 (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by:	{0 480}			
{0 780} SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment 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;	{0 780}	Not reviewed during this survey.		

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{0 780}	Continued From page 4 (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 record review and interview, the licensee failed to comply with Minnesota State Fire Code Rules, Chapter 7511. 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 the potential to affect a large portion or all of the residents). The findings include: On March 27, 2025, at 12:35 p.m., the surveyor emailed licensed assisted living director (LALD)-A requesting documentation to support corrections for the 0780 tag pursuant to a survey completed on December 5, 2024. On March 27, 2025, at 3:37 p.m., LALD-A emailed a proposed written	{0 780}			

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{0 780}	Continued From page 5 plan from their system provider and indicated the the project would be completed upon plan approval from the State of Minnesota. Additionally, the licensee provided a plan of correction for violation tag number 780 tag, dated February 7, 2025. During an interview on April 4, 2025, at 12:29 p.m., chief clinical officer (CCO)-J stated the plan review application for the 0780 tag correction project was submitted on March 27, 2025. CCO-J stated the company hired for the project would be scheduled to begin the work mid-late April.	{0 780}			
{0 790} SS=F	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by:	{0 790}			
{0 800} SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds,	{0 800}	Not reviewed during this survey.		

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{0 800}	Continued From page 6 systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by:	{0 800}	Not reviewed during this survey.		
{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) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff 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	{0 810}			

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01880	Continued From page 8 The findings include: On March 24, 2025, at 11:40 a.m., the surveyor and licensed practical nurse (LPN)-N observed the medication refrigerator's current temperature, located in the locked nurse's office, was 34 degrees Fahrenheit (F). LPN-N stated the medication refrigerator temperature was checked every night by a unlicensed personnel (ULP). The medication refrigerator contained ten unopened Novolog insulin FlexPens for R7, one unopened Mounjaro single dose pen for R16 and four unopened aspart insulin pens for R17. The licensee's Medication Refrigerator Temperature Logs dated February 1, 2025, through March 21, 2025, indicated to check the temperature daily on overnights (NOC) and refrigerator temperatures needs to be at 36 to 41 degrees (2 to 5 Celsius), 40 degrees F is the ideal temperature. The temperatures recorded during the above dates was as follows: no temperatures documented 16 out of 51 opportunities, and temperatures documented 31 F to 34 degrees F, 33 out of 51 opportunities. On March 24, 2025, at 11:45 a.m., LPN-N stated the refrigerator temperatures should have been between 36 degrees F to 41 degrees F according to the temperature log sheet. LPN-N stated staff are trained to document the temperature every night and should call the nurse if the temperature is outside the parameters. On March 24, 2025, at 12:15 p.m., clinical nurse supervisor (CNS)-B stated staff are trained to document the medication refrigerator every night and should have reported to the nurse the temperature was outside of the parameter.	01880			

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01880	Continued From page 9 The manufacturer's instructions for Novolog dated October 2021, indicated to store unopened Novolog FlexPens in the refrigerator at 36 to 46 degrees F. Do not allow Novolog insulin to freeze. The manufacturer's instructions for Mounjaro dated May 2024, indicated to store unopened Mounjaro in the refrigerator at 36 to 46 degrees F. Do not freeze the pen. If the pen is frozen, throw the pen away and use a new pen. The manufacturer instructions for aspart insulin pens dated March 2023, indicated to store unopened aspart insulin pens in the refrigerator at 36 to 46 degrees F. Do not allow aspart insulin to freeze. The licensee's Storage of Medications policy dated August 1, 2021, indicated medications shall be stored consistent with manufacturer's recommendations (refrigerated, room temperature, or frozen). And refrigerator will be monitored for temperature compliance. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880			
{01890} SS=F	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.	{01890}			

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{01890}	Continued From page 10 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure time sensitive medications included the opened-on date and expiration dates for five of five residents (R6, R9, R14, R15, R16). 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: On March 24, 2025, from 11:00 a.m. through 11:45 a.m., the surveyor observed medication storage rooms and carts for facility identifiers (B1, B2, B3 and Aspen first floor and second floor) with unlicensed personnel (ULP)-K, ULP-L and ULP-M respectively. ULP-K, ULP-L and ULP-M confirmed the following medications below in the respective work areas: -R6's opened Spiriva Respimat 2.5 microgram (mcg) inhaler (treats respiratory conditions) lacked an open and expiration date; -R9's opened fluticasone propionate/salmeterol diskus (treats respiratory conditions) 100 mcg/50 mcg lacked an open and expiration date; -R14's opened Lantus insulin 100 units/milliliter (ml) pen (a multiple dose pen shaped injector device for insulin administration to treat diabetes) lacked an open and expiration date; -R15' s Tresiba FlexTouch 100 units/ml pen (a multiple dose pen shaped injector device for	{01890}			

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{01890}	Continued From page 11 insulin administration to treat diabetes) lacked an open and expiration date; and -R16's open olopatadine hydrochloride ophthalmic solution (treats eye allergies) lacked an open and expiration date. Manufacturer instructions for Spiriva Respimat inhaler dated July 2022, indicated exchange the cartridge three months after insertion. Manufacturer instructions for fluticasone propionate/salmeterol dated November 2024, indicated to discard after 3 months from removing from the foil. Manufacturer's instructions for Lantus insulin, dated June 2022, indicated to discard the pen 28 days after it had been opened, even if it still had insulin left in it. Manufacturer's instructions for olopatadine eye drops dated September 20, 2023, indicated to discard the container at the end of the treatment or four weeks after opening whichever comes first. Manufacturer's instructions for Tresiba insulin, dated July 2022, indicated to discard the pen 56 days after it had been opened, even if it still had insulin left in it. On March 24, 2025, at 11:12 a.m., registered nurse (RN)-I stated all time sensitive medications should be labeled with open and expiration dates. The Licensee's Medication Storage policy dated December 13, 2021, indicated when the facility receives a prescription drug for immediate or later administration, the prescription drug must be kept in the original container in which it was dispensed	{01890}			

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{01890}	Continued From page 12 by the pharmacy bearing the original prescription label with legible information including expiration or beyond use date of a time dated drug. No further information was provided.	{01890}			
{02040} SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by:	{02040}			
{02310} SS=F	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	{02310}	Not reviewed during this survey.		

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{02310}	Continued From page 13 services according to acceptable health care, medical, or nursing standards for storage of cleaning supplies. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On March 24, 2025, at 10:45 a.m., the surveyor observed the laundry room door closed but unlocked in the secured dementia care unit. Unlicensed personnel (ULP)-K stated the laundry room door was suppose to be locked. ULP-K stated ULP-K forgot to lock the door after she left the laundry room. The surveyor and ULP-K observed the following chemicals within reach on the shelf above the washer and dryer: -one opened bottle Bissell multi-cleaner carpet cleaner; -one large opened Ultra Clean laundry detergent; -three open bottles of germicidal cleaner; -one open bottle of Resolve pet expert cleaner; -one opened Concrobium Mold Control spray; -one opened and one unopened bottle of Shout stain remover; and -one open bottle of Odoban odor control. On March 24, 2025, from 10:48 a.m., through 11:00 a.m., the surveyor and ULP-K observed the following chemical in a resident room in the dementia care unit: -R8, one open bottle of Lysol toilet bowl cleaner	{02310}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30361	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 03/26/2025
NAME OF PROVIDER OR SUPPLIER ARBOR PARK LIVING CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2921 6TH AVENUE NORTH MOORHEAD, MN 56560		
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{02310}	Continued From page 14 sitting on bathroom floor by toilet. On March 24, 2025, at 12:11 p.m., registered nurse (RN)-I stated staff are trained to keep the laundry room door locked. On March 24, 2025, at 12:12 p.m., licensed assisted living director (LALD)-A stated no chemicals should be in the secured dementia unit resident rooms. LALD-A stated the staff had been trained on this and was unsure why this chemical was left in the resident room. The safety data sheet for Bissell multi-purpose carpet cleaner dated June 20, 2023, indicated it was a hazardous chemical and to avoid inhalation, ingestion, or contact with eyes, skin, or clothing. The safety data sheet for Ultra Clean laundry detergent dated February 13, 2017, indicated it was a hazardous chemical and to avoid inhalation, ingestion, or contact with eyes and skin. The safety data sheet for germicidal cleaner dated October 29, 2021, indicated it was a hazardous chemical, and to avoid inhalation, ingestion or contact with eyes and skin. The safety data sheet for Resolve pet expert cleaner dated October 23, 2024, indicated it was a hazardous chemical, and to avoid inhalation, ingestion or contact with eyes and skin. The safety data sheet for Concrobium mold control dated February 8, 2017, indicated it was a hazardous chemical, and to avoid inhalation, ingestion or contact with eyes and skin.	{02310}			

Minnesota Department of Health

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{02310}	Continued From page 15 The safety data sheet for Shout laundry stain remover dated November 30, 2017, indicated it was a hazardous chemical, and to avoid inhalation, ingestion or contact with eyes and skin. The safety data sheet for Lysol toilet bowl cleaner dated October 25, 2016, indicated it was a hazardous chemical and to avoid inhalation, ingestion, or contact with eyes, skin, or clothing. No further information was provided.	{02310}			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

January 17, 2025

Licensee

Arbor Park Living Center LLC

2921 6th Avenue North

Moorhead, MN 56560

RE: Project Number(s) SL30361016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on December 6, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, 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.

The enclosed State Form documents no violations. MDH documents the state correction orders using federal software. Please disregard the heading of the fourth column that states, "Provider's Plan of Correction." A plan of correction is not required.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement.

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;

Level 3: a fine of \$3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.

Level 4: a fine of \$5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.31, Subd. 4(a)(5), MDH may impose fine amounts of either \$1,000 or \$5,000 to licensees who are found to be responsible for maltreatment. MDH may impose a fine of \$1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. MDH also may impose a fine of \$5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

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

St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - \$3,000.00

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

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

INFORMAL CONFERENCE

In accordance with Minn. Stat. § 144A.475, Subd. 8 OR Minn. Stat. § 144G.20, Subd. 20, the Commissioner of Health is authorized to hold a conference to exchange information, clarify issues, or resolve issues.

The Department of Health staff would like to schedule a conference call with Arbor Park Living Center LLC. Please contact Jessie Chenze at 507-344-2730 **on or before Thursday, January 23, 2025**, to schedule the conference call.

REQUESTING A HEARING

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

Arbor Park Living Center LLC

January 17, 2025

Page 3

To submit a hearing request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **<https://forms.office.com/g/Bm5uQEPhVa>**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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,

A handwritten signature in cursive script that reads "Jessie Chenze".

Jessie Chenze, Supervisor

State Evaluation Team

Email: Jessie.Chenze@state.mn.us

Telephone: 218-332-5175 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30361	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/06/2024
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0 000	Initial Comments 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: SL30361016-0 On December 2, 2024, through December 6, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 45 residents; 45 receiving services under the Assisted Living Facility with Dementia Care license. An immediate correction order was issued for SL30361016 for tag identification of 1290 at a pattern scope, level three (H).	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 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 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 evaluators ' 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 SUBDIVISION 1-3.		
0 100 SS=F	144G.10 Subdivision 1 License required (a)(1)Beginning August 1, 2021, no assisted living	0 100			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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0 100	Continued From page 1 facility may operate in Minnesota unless it is licensed under this chapter. (2) No facility or building on a campus may provide assisted living services until obtaining the required license under paragraphs (c) to (e). (b)The licensee is legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. Nothing in this chapter shall in any way affect the rights and remedies available under other law. (c) Upon approving an application for an assisted living facility license, the commissioner shall issue a single license for each building that is operated by the licensee as an assisted living facility and is located at a separate address, except as provided under paragraph (d) or (e). (d) Upon approving an application for an assisted living facility license, the commissioner may issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility. An assisted living facility license for a campus must identify the address and licensed resident capacity of each building located on the campus in which assisted living services are provided. (e) Upon approving an application for an assisted living facility license, the commissioner may: (1) issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility with dementia care, provided the assisted living facility for dementia care license for a campus identifies the buildings operating as assisted living facilities with dementia care; or (2) issue a separate assisted living facility with dementia care license for a building that is on a campus and that is operating as an assisted living facility with dementia care.	0 100			

Minnesota Department of Health

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0 100	Continued From page 2 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to obtain accurate licensure when they applied for a license for a residential dwelling, despite sharing one roof with a building that occupied offices for other business than the assisted living. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's health facility identification (HFID) 30361, included a detached building (B3) with an address of 520 23 Street North, Moorhead MN, with four residents currently living there, out of a possible census of 10. On December 2, 2024, from 12:45 p.m. through 1:57 p.m., the surveyor toured the campus with office personnel (OP)-F. During the tour, the surveyor observed B3, a detached building from the rest of the campus. B3 had 10 units as part of the assisted living license, sharing the roof with offices on the other side of the building by going through two glass doors. The first glass door (which was locked) opened to a small hallway where 2 unoccupied units of the 10 units were located. The second glass door led to offices.	0 100			

Minnesota Department of Health

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0 100	Continued From page 3 OP-F stated the licensed assisted living director (LALD), and chief clinical officer (CCO) offices for the assisted living facility were located on the office side, as well as a business manager and information technologist (IT) that had other business affiliations. OP-F was unaware of any variance for the offices not occupied by the licensee. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 100			
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to	0 480			

Minnesota Department of Health

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0 480	Continued From page 4 provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 480			

Minnesota Department of Health

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0 480	Continued From page 5 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated December 2, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure infection	0 510			

Minnesota Department of Health

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0 510	Continued From page 6 control standards were followed for one of two employees, (unlicensed personnel (ULP)-C) during medication administration. 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 clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally or in a limited number of locations). The findings include: On December 3, 2024, from 7:15 a.m. to 8:10 a..m., the surveyor observed the following: - ULP-C washed hands and donned (put on) disposal gloves, completed morning medication administration for R2 and removed disposable gloves. The surveyor did not observe ULP-C wash hands after removing gloves. - ULP-C donned disposal gloves, completed morning medication administration for R1 and removed disposable gloves. The surveyor did not observe ULP-C wash hands before donning gloves or after removing gloves, or in between residents. On December 3, 2024, at 8:10 a.m., ULP-C stated she washes her hands or uses hand sanitizer in between resident cares when wearing disposable gloves, but not when wearing disposable gloves for administering medications. On December 3, 2024, at 8:40 a.m., clinical nurse supervisor (CNS)-B stated expectations for handwashing include before donning and removal	0 510			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30361	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/06/2024
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0 510	Continued From page 7 of gloves, as well as in between resident cares. The licensee's Infection Control 8.07 Gloves policy, dated February 23, 2022, indicated to wash hands before applying gloves to both hands, dispose of used gloves in proper receptacle and rewash hands. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510			
0 650 SS=D	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057.	0 650			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30361	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/06/2024
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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
0 650	Continued From page 8 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records contained the required training content for one of one employee (unlicensed personnel (ULP)-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 is issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-E was hired on February 3, 2023, to provide direct care services under the licensee's assisted living license with dementia care license. On December 3, 2024, at 10:45 a.m., the surveyor observed ULP-E administer R3's 11:00 a.m. scheduled medications. ULP-E's employee records lacked documentation ULP-E had been trained in preparing medication and demonstrated competency to the registered nurse (RN) for medication for unplanned times away. On December 4, 2024, at 12:09 p.m., RN-I stated ULP-E was trained on medications for unplanned times away. RN-I presented the training material but stated the competency was not documented in staff records.	0 650			

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0 650	Continued From page 9 The licensee's Medication Management-Planned and Unplanned Time Away policy dated December 13, 2021, indicated for unplanned resident times away when a pharmacist or licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0190, Subp. 6, effective October 2022, the licensee must maintain a record of staff training and competency required under this part and Minnesota Statutes, chapter 144G, that documents the following information for each competency evaluation, training, retraining, and orientation topic: (1) facility name, location, and license number; (2) name of the training topic or training program, and the training methodology, such as classroom style, web-based training, video, or one-to-one training; (3) date of the training and competency evaluation, and the total amount of time of the training and competency evaluation; (4) name and title of the instructor and the instructor's signature, and the name and title of the competency evaluator, if different from the instructor, and the evaluator's signature with a statement attesting that the employee successfully completed the training and competency evaluation; and (5) name and title of the staff person completing the training, and the staff person's signature with statement attesting that the staff person successfully completed the training as described in the training documentation.	0 650			

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0 650	Continued From page 10 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the Emergency	0 680			

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0 680	Continued From page 11 Preparedness Plan (EPP) was prominently posted and reviewed annually, and failed to ensure the missing resident policy was reviewed quarterly. This had the potential to affect all residents, staff, and any visitors of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's undated EPP was not posted prominently and lacked documentation the EPP was reviewed annually. The licensee's undated Missing Resident policy lacked documentation the policy was reviewed quarterly. On December 5, 2024, at 10:51 a.m., clinical nurse supervisor (CNS)-B stated the EPP was kept in the locked office. CNS-B stated the leadership staff have talked about these policies but does not know if anything was documented and would have to ask the chief clinical officer (CCO)-J). The licensee's undated 4.13 Missing Resident Policy, did not indicate when the facility would review this policy. Per Assisted Living Facilities: Minnesota Rules Chapter 4659, 4659.0110, Subp. 4. Review missing resident plan. The assisted living director	0 680			

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0 680	Continued From page 12 and clinical nurse supervisor must review the missing person plan at least quarterly and document any changes to the plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680			
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment 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:	0 780			

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0 780	Continued From page 13 Based on observation, record review, and interview, the licensee failed to comply with smoke alarm requirements and Minnesota State Fire Code Rules, Chapter 7511. 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 the potential to affect a large portion or all of the residents). The findings include: On December 5, 2024, at 12:00 p.m., the surveyor toured the facility with office personnel (OP)-F. During the tour, the surveyor observed the following: Door Locking: 1. Keypad locks were installed on the emergency exit doors in the Oaks, Birch, and Pines buildings. A switch to break the power for the egress control locking systems was not installed in these buildings. During the facility tour interview on December 5, 2024, OP-F verified the above listed observations. The egress control locking system shall have the capability of being unlocked by a signal or switch from the fire command center, a nursing station, or other approved location. The signal or switch shall directly break power to the lock. Egress control locking systems must comply with Minnesota State Fire Code Rules, Chapter 7511. 2. Keypad locks on the emergency exit doors in the Pines building required entry of a code to	0 780			

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0 780	Continued From page 14 open the doors. The surveyor attempted to open the doors without entering a code, and the door locks did not release. The Pines building had residents onsite and no employees were observed working in the building at the time of the tour. OP-F stated during the facility tour interview on December 5, 2024, that these doors would not open unless a code was entered into the keypad and verified the above listed observations. OP-F stated this building was not operating as dementia care and was kept locked to control who could enter the building from the outside. Controlled egress door locking systems, including electromechanical locking systems are only permitted in Groups I-1, I-2, R-3, and R-4 occupancies when a person's clinical needs require their containment and when 24-hour resident or patient supervision is provided within the secured area. Aspen Building: 3. Emergency exit door 8 in the dining room did not fully open and the bottom of the door was catching on the concrete pad outside the door. Emergency exit doors to the outside must swing completely open to provide unobstructed access to the exterior of the building. 4. Labeled one hour fire doors for the laundry room and storage/mechanical room were held open by wedges. Labeled 20 minute fire doors for the nurse office and unoccupied resident room 108 were held open by wedges. Devices used to hold open fire doors must not prohibit the required operation and closing feature of the door. 5. The door closer had been removed from the labeled 20 minute fire door for the central office. This fire door had been modified by splitting it in half horizontally, allowing the top half to open while the bottom half remained closed. All components of a fire door assembly must be	0 780			

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0 780	Continued From page 15 maintained as designed. 6. The labeled 20 minute fire doors did not self close and positively latch for occupied resident rooms 106, 204, 209, and 220. 7. Extension cords were used to supply power in the nurse office and in resident room 220. The improper use of extension cords creates a fire hazard. 8. The escutcheon plate was missing from the fire sprinkler in the dining room storage closet. Missing escutchen plates can delay the activation of the sprinkler head in the event of a fire. Oaks Building: 9. Burnt cigarettes had been disposed of on the back patio along the edge of the building, creating a fire hazard. 10. Labeled 20 minute fire doors were held open with bricks for resident rooms 5 and 7. 11. The labeled 20 minute fire door was held open by a wedge for resident room 6. Pines Building: 12. In resident bedroom 4, a smoke detector was installed without a horn strobe or speaker base. A smoke alarm was not installed in resident bedroom 4. 13. A smoke alarm was not installed in resident bedroom 8. 14. When smoke alarms in resident bedrooms were tested by OP-F, none of the other dwelling unit smoke alarms were actuated. When smoke alarms outside the sleeping areas were tested by OP-F, none of the other dwelling unit smoke alarms were actuated. The dwelling units smoke alarms were not interconnected. 15. An illuminated exit sign was installed at the door leading into the office area from the resident day room. A battery operated keypad lock was installed on the door above a lock that required a key to open. On the office side of the door, a sliding bolt lock was installed at the top of the	0 780			

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0 780	Continued From page 16 door. The posted emergency escape floor plan labeled this door as an exit route. The use of this type of door locking hardware would delay escape in the event of an emergency. Means of egress must comply with Minnesota State Fire Code Rules, Chapter 7511. Exterior of Facility: 16. The emergency evacuation floor plan for the Aspen building showed exit routes leading into the courtyard from the links between the Aspen and Oaks/Birch buildings. A path clear of snow had not been maintained outside of these doors. OP-F verified during the facility tour interview that paths leading away from the link side doors were not maintained free of snow during the winter. During the facility tour interview on December 5, 2024, OP-F verified the above listed observations. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780			
0 790 SS=F	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced	0 790			

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0 790	Continued From page 17 by: Based on observation and interview, the licensee failed to maintain the portable fire extinguishers as required by statute. This deficient condition had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: On December 5, 2024, at 12:00 p.m., the surveyor toured the facility with office personnel (OP)-F. During the tour, the surveyor observed monthly inspections had not been recorded on the back of the tags attached to the portable fire extinguishers. Fire extinguisher inspections must be conducted every month to ensure each extinguisher is in its designated place, it has not been tampered with, and there is no obvious physical damage or condition that would interfere with its use or operation. During the facility tour interview on November 5, 2024, OP-F called environmental (E)-D on the phone. E-D verified monthly fire extinguisher inspection records were not available. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790			
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment	0 800			

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0 800	Continued From page 18 (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, record review, and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect a limited number of residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On December 5, 2024, at 12:00 p.m., the surveyor toured the facility with office personnel (OP)-F. During the tour, the surveyor observed the following: Aspen Building: 1. The plastic panel was cracked on the fire extinguisher cabinet in the dining room.	0 800			

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0 800	Continued From page 19 Birch Building: 2. One door was missing from the frame for the double set of doors for the entrance into the Birch building from the Aspen building. 3. The trim around the bathroom doorway was loose in resident room 4. 4. In the laundry room, the plastic flexible dryer duct connected to the clothes dryer had several small holes in the ducting. The improper use of plastic flexible dryer duct between the vent and the clothes dryer creates a fire hazard. Oaks Building: 5. The glass door leading out of the secure dementia care unit into the link did not self close and positively latch as designed. Pines Building: 6. Sliding bolt locks were installed at the top of the doors on a resident bathroom across the hall from rooms 5 and 6 and on the door for unoccupied resident room 4. 7. In the mechanical room, there was a rectangular-shaped hole in the wall above the electrical panel. 8. A ceiling tile was missing in the office. Exterior of Facility: 9. A latch was not installed on the side of the fence gate accessible to the building occupants for the Aspen, Oaks, and Birch buildings. The latch and pull cord used to unlock the fence gate was installed on the side of the gate facing the parking lot. The emergency evacuation floor plans labeled exits leading into the courtyard and backyard enclosed by this fence. During the facility tour interview on December 5, 2024, OP-F verified the above listed observations. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800			

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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) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff 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 staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to develop and	0 810			

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0 810	Continued From page 21 maintain a fire safety and evacuation plan with the required content, make the plan readily available, and provide required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On December 5, 2024, at 12:00 p.m., the surveyor toured the facility with OP-F. During the tour, the surveyor observed the fire safety and evacuation plan was not located in a central location for all staff accessibility in each building. Floor plans were posted but copies of the full FSEP with employee actions and resident protection procedures were not readily available. On December 5, 2024, office personnel (OP)-F provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and employee evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee FSEP failed to include the location and number of resident sleeping rooms. On December 5, 2024, at 12:00 p.m., the surveyor toured the facility with OP-F. During the tour, the surveyor observed the following: 1. Aspen building resident room 216 was not labeled on the 2nd floor emergency evacuation	0 810			

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0 810	Continued From page 22 floor plan. 2. Birch building resident room 5 has a sign posted at the door identifying this room as resident room 10. 3. A number was not posted at the door for resident room 4 in the Pines building. During the facility tour interview, on December 5, 2024, OP-F verified the above listed observations. The licensee FSEP was not developed and maintained. 4. The FSEP failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks for the Pines building. 5. The FSEP failed to identify fire protection procedures necessary for residents in the Pines building. 6. Multiple copies of the facility FSEP were provided to the surveyor for review. The FSEP procedures referenced employees who were no longer employed at the facility. 7. The FSEP directed the building occupants to evacuate to the nearest parking lot in front of the Aspen and Birch buildings or behind Elm. On December 5, 2024, at 12:00 p.m., the surveyor toured the facility with OP-F. During the tour, an Elm building was not identified. 8. Evacuation procedures from the Oaks and Pines buildings were not included in the FSEP. 9. The procedures in the FSEP did not identify each building by physical address. The emergency evacuation floor plans for the Oaks, Birch, and Pines buildings did not identify the physical address of the buildings or include the Oaks, Birch, and Pines names that were used to identify these buildings during the facility tour on December 5, 2024, at 12:00 p.m. with OP-F. The FSEP floor plans must be developed to	0 810			

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0 810	Continued From page 23 accurately identify each building. 10. The posted emergency evacuation floor plan for the Aspen building did not label the exit doors. 11. The FSEP procedures for the operations of the unlocking system for the emergency exit doors with keypads were not described in the plan. The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents evident by a lack of these procedures in the plan. The FSEP shall be developed and maintained to provide efficient communication for exiting in the event of a fire or similar emergency. During an interview, on December 5, 2024, at 4:45 p.m., OP-F verified the FSEP required revision. TRAINING Record review indicated the licensee failed to make fire safety and evacuation training available to residents capable of assisting in their own evacuation at least once per year. A training record indicated residents and staff attended a training session on June 12th with the Moorhead Fire Department. The year of this training was not recorded. No additional resident training records were provided. During an interview on December 5, 2024, at 4:45 p.m., OP-F verified the training requirements were not met. DRILLS Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month evident by the lack of evacuation drill logs. No evacuation drill records	0 810			

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0 810	Continued From page 24 were provided. During an interview on December 5, 2024, at 4:45 p.m., OP-F stated fire drills were completed at the same time as staff training on fire and emergency, but drill records had not been maintained. OP-F verified the evacuation drill frequency was not met and the required drill documentation not recorded. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
0 950 SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a	0 950			

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0 950	Continued From page 25 designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to offer the resident the opportunity to identify a designated representative in writing for three of three residents (R1, R2, R3). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 R1's diagnoses included altered mental status, hypertension (high blood pressure), and anxiety. R1's service plan dated June 2, 2023, indicated the resident received medication administration, assistance with transferring, toileting, bathing, grooming, dressing, laundry, and housekeeping. R2 R2's diagnoses included vascular dementia, hypertension, and anxiety. R2's undated service plan, indicated the resident received medication administration, assistance with toileting, bathing, dressing, grooming, laundry, and housekeeping.	0 950			

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0 950	Continued From page 26 R3 R3's diagnoses included diabetes, bipolar (episodes of mood swings), and anxiety. R3's undated service plan indicated the resident received medication administration, assistance with catheter care, transferring, toileting, bathing, grooming, laundry, and housekeeping. R1, R2, and R3's records lacked evidence of a notice with the required statutory language for the resident to identify a designated representative or documentation that R1, R2 or R3 declined to name a designated representative. On December 5, 2024, at 10:50 a.m., clinical nurse supervisor (CNS)-B stated in August 2024, the residents was supposed to be given new designated representative documents with the correct statutory language, however, the wrong document was given. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950			
01290 SS=H	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under	01290			

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01290	Continued From page 27 section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: This correction order was modified on December 4, 2024, to reflect additional information provided by the licensee. The order was changed from a level three widespread, to a level three pattern scope. Based on observation, interview, and record review, the licensee failed to ensure background studies were cleared prior to staff providing services to residents, for two of three employees (unlicensed personnel (ULP)-C, ULP-G). This resulted in an immediate correction order issued on December 3, 2024, and had the potential to affect all residents. This practice resulted in a level three violation (a violation that harmed a client'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 found to be pervasive). The findings include: On December 3, 2024, at 12:00 p.m., the surveyor reviewed the licensee's NETStudy 2	01290			

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01290	Continued From page 28 (web-based system to ensure eligibility of staff performing services) roster, of the current employees, printed December 3, 2024, by office personnel (OP)-F. ULP-C and ULP-G background clearance was determined to be in process. ULP-C ULP-C was hired April 3, 2024, to provide direct care services to the licensee's residents. Time card records indicate ULP-C had worked with residents unsupervised averaging 32-56 hours per 2 week pay period since May 1, 2024. On December 3, 2024 at 7:45 a.m., the surveyor observed ULP-C administer R1's morning medications. ULP-G ULP-G was hired April 2, 2024, to provide direct care services to the licensee's residents. Time card records indicate ULP-G had worked with residents unsupervised averaging 64 hours per 2 week pay period since April 29, 2024. On December 3, 2024, at 12:30 p.m., OP-F stated it was difficult getting some background checks completed, and had called the Department of Human Services (DHS) to inquire, and DHS told OP-F the studies were in progress. OP-F stated ULP-C needed to fill out a form and return in order to get her background check finalized. OP-F stated she had called DHS about a week ago to inquire about ULP-G and was told by DHS he was good to work, however, OP-F received no documentation. OP-F stated she was not aware staff needed to be supervised until the background study was cleared or had	01290			

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01290	Continued From page 29 documentation from DHS indicating otherwise. The licensee's 4.02 Background Studies policy dated December 21, 2023, indicated if hired prior to receiving the results of the background study, or the tentative background study results indicate more time is needed requiring supervision, new hires shall not be permitted to interact or provide services to tenants or clients of Arbor Park Assisted Living except under the direct supervision (eyesight) of another qualified staff person. Once an approved background study has been received, staff may act independently of residents, assuming all other requirements have been met. Copies of completed background studies shall be kept in individual employee records. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	01290			
01420 SS=E	144G.62 Subd. 2 Delegation of assisted living services (b) When the registered nurse or licensed health professional delegates tasks to unlicensed personnel, that person must ensure that prior to the delegation the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each resident and is able to demonstrate the ability to competently follow the procedures and perform the tasks. If the unlicensed personnel has not regularly performed the delegated assisted living task for a period of 24 consecutive months, the unlicensed personnel must demonstrate competency in the task to the registered nurse or appropriate licensed health professional. The registered nurse or licensed	01420			

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01420	Continued From page 30 health professional must document instructions for the delegated tasks in the resident's record. 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) provided written instructions in the resident's record for the delegated task provided by the unlicensed personnel (ULP) for two of two residents (R2, R3) who received catheter cares from the licensee. 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 R2's diagnoses included vascular dementia, hypertension (high blood pressure), and anxiety. R2's undated service plan, indicated staff assistance for medication administration, bathing, toileting, vital sign monitoring, housekeeping, and laundry. On December 3, 2024, at 7:15 a.m., the surveyor observed ULP-C administer R2's scheduled morning medications. ULP-C stated R2's catheter bag was emptied by the night shift. The surveyor observed R2's catheter bag with a small amount	01420			

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01420	Continued From page 31 of urine. R2's EMAR dated November 2024, indicated to empty catheter bag and record output three times a shift and as needed. Empty bag every shift and as needed. (both directions on EMAR). R2's record lacked specific instructions for catheter cares, conflicting tasks to empty catheter bag, and when to notify RN. R3 R3's diagnoses included type 2 diabetes, bipolar (mood swings) and hypertension. R3's undated service plan indicated staff assistance for medication administration, blood sugars, transfers, toileting, catheter output, dressing, bathing, vital sign monitoring, laundry, and housekeeping. On December 3, 2024, at 10:45 a.m., the surveyor observed ULP-E administer R3's 11:00 a.m. scheduled medications. On December 3, 2024, at 10:50 a.m., the surveyor observed ULP-E flush catheter tubing using a graduated cylinder. ULP-E stated the graduated cylinder was marked for amount of vinegar to put in and water and did not know when the tubing or bag needed to be changed. R3'S EMAR dated December 2024 indicated R3 had a catheter flush daily- separate and flush catheter bag daily with water/vinegar combination. Then tape the hose to the foley tubing. R3's record lacked specific written instructions to include parameters for monitoring R2's catheter	01420			

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01420	Continued From page 32 cares and when to notify the RN. On December 4, 2024, at 2:00 p.m., clinical nurse supervisor (CNS)-B stated there was not specific instructions for R2 and R3's catheter cares, or when to notify the RN. The licensee's Delegation of Assisted Living Services policy dated December 13, 2021, indicated the RN or licensed health professional will document instructions for the delegated tasks in the resident record. The RN may delegate nursing services to a person who has successfully completed staff orientation, who has been trained in the service to be provided, and who has demonstrated to the RN the ability to competently follow the procedures for the resident. These services include routine delegated medical and nursing procedures, such as catheter procedures. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01420			
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment	01440			

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01440	Continued From page 33 administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure direct supervision of staff performing delegated tasks was provided within 30 calendar days after the date on which the individual begins working for the licensee for one of two (unlicensed personnel (ULP)-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: ULP-E was hired on February 3, 2023, to provide direct care services under the licensee's assisted living with dementia care license.	01440			

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01440	Continued From page 34 On December 3, 2024, at 10:45 a.m., the surveyor observed ULP-E administer R3's 11:00 a.m. scheduled medications. ULP-E's employee record lacked documentation of a registered nurse (RN) supervising ULP-E performing delegated tasks within 30 days of beginning work with the licensee. On December 4, 2024, at 11:54 a.m., clinical nursing supervisor (CNS)-B stated she was unable to find ULP-E's documented 30-day direct supervision as required. The licensee's 6.17 Supervision of Staff - Delegated Services policy dated February 23, 2022, indicated direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for (facility name) assisted living and first performs the delegated tasks for residents and thereafter as needed based on performance. Documentation of supervision activities will be retained in the employee's record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440			
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	01500			

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01500	Continued From page 35 training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication;	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
01500	Continued From page 36 (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an employee received all of the required annual training content for each 12 months of employment for one of three employees (clinical nurse supervisor (CNS)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: CNS-B was hired November 14, 2022, to provide direct care services under the licensee's assisted living with dementia care license. CNS-B's employee record lacked evidence CNS-B completed the following required annual training: - training on reporting of maltreatment of vulnerable adults under Mandated Reporting of	01500			

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01500	Continued From page 37 Maltreatment of Vulnerable Adults Chapter 626.557; - review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; - 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; and -the principles of person-centered planning and service delivery and how they apply to direct support services provided by a staff person. On December 4, 2024, at 8:52 a.m., CNS-B stated she was behind on her annual training, because she has been too busy. The licensee's 5.06 Annual Required Staff Training policy dated December 20, 2021, indicated all staff that perform direct care services at [facility name] assisted living will complete at least 8 hours of annual training for each 12 months of employment. The following training elements must be included every 12 months to all staff who performs direct care services: -training on reporting of maltreatment of vulnerable adults under section 626.557; - review of the assisted living bill of rights and staff responsibilities related to ensuring the	01500			

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01500	Continued From page 38 exercise and protection of those rights; - 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;and - 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; and -the principles of person-centered planning and service delivery and how they apply to direct support services provided by a staff person. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500			
01540 SS=D	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the	01540			

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01540	Continued From page 39 requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a direct care employee received the required annual dementia training for each 12 months of employment for one of three employees (clinical nurse supervisor (CNS)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: CNS-B was hired November 14, 2022, to provide direct care services under the licensee's assisted living with dementia care license. CNS-B's employee record lacked evidence CNS-B completed two hours of dementia training for each 12 months of employment. On December 4, 2024, at 8:52 a.m., CNS-B stated she was behind on her annual training, because she has been too busy.	01540			

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01540	Continued From page 40 The licensee's Dementia Training policy dated December 15, 2021, indicated assisted living with dementia care licensed facilities would have all staff complete the two hours of additional training for each 12 months of work thereafter. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01540			
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 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	01650			

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01650	Continued From page 41 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 observation, interview, and record review, the licensee failed to ensure the service plan included the required content for three of three residents (R1, R2, 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) 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 R1's diagnoses included altered mental state, hypertension (high blood pressure), and anxiety. On December 3, 2024, at 7:45 a.m., the surveyor observed unlicensed personnel (ULP)-C administer R1's scheduled morning medications. R1's service plan dated June 2, 2023, indicated staff assistance for medication administration, transfers, ambulation, dressing, toileting, bathing, housekeeping and laundry. R1's electronic medication administration record dated November 2024, indicated compression stockings on in the morning and off at night. R1's service plan lacked the following required	01650			

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01650	Continued From page 42 content: - compression stockings on in the morning and off at night; - the circumstances in which emergency medical services are not to be summoned consistent with chapters 145 B and 145C, and declarations made by the resident under those chapters. R2 R2's diagnoses included vascular dementia, hypertension, and anxiety. On December 3, 2024, at 7:15 a.m., the surveyor observed ULP-C administer R2's scheduled morning medications. R2's undated service plan indicated staff assistance for medication administration, bathing, toileting, vital sign monitoring, housekeeping and laundry. R2's service plan lacked the following required content: - catheter cares; - 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 - 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. R3 R3's diagnoses included type 2 diabetes, bipolar (mood swings) and hypertension.	01650			

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01650	Continued From page 43 On December 3, 2024, at 10:45 a.m., the surveyor observed ULP-E administer R3's 11:00 a.m. scheduled medications. R3's undated service plan indicated staff assistance for medication administration, blood sugars, transfers, toileting, catheter output, dressing, bathing, vital sign monitoring, laundry and housekeeping. R3's service plan lacked the following required content: - catheter cares; - 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 included: - the actions to be taken if the scheduled service cannot be provided; - information and a method to contact the facility; - 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 - the circumstances in which emergency medical services are not to be summoned consistent with chapters 145 B and 145C, and declarations made by the resident under those chapters. On December 4, 2023, at 10:50 a.m., clinical nurse supervisor (CNS)-B stated she was unable to find R2's last page of the service plan, or R3's service plan (surveyor received service plan from the electronic health record). CNS-B stated she was unsure why summoning emergency services	01650			

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01650	Continued From page 44 wasn't filled out on R1's service plan. The licensee's Service Plan policy dated December 10, 2021, indicated the service plan would include the following: - a description of the services that are to be provided based on the most recent assessment and resident preferences; - fees for services to be provided; - the frequency of each service to be provided based on the most recent assessment and resident preferences; - an identification if staff or categories of staff who will be providing services (registered nurse (RN), licensed practical nurse (LPN), ULP, etc.) - a schedule and method for the next planned assessment or monitoring; and - a schedule and method for the next planned monitoring of staff providing services. A contingency plan that included: - action [facility name] assisted living will take if scheduled services cannot be provided; - information regarding how the resident can contact [facility name] assisted living; - the names and contact information the resident wishes, if any, to have notified in an emergency or if there is a significant adverse change in the resident's condition; - identification and contact information of who the resident has authorized, if any, to sign for the resident in an emergency; and - how the facility will support documented resident health care directive decisions, if any-including circumstances when emergency medical services are not to be summoned. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650			

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01690 SS=F	144G.71 Subdivision 1 Medication management services (a) This section applies only to assisted living facilities that provide medication management services. (b) An assisted living facility that provides medication management services must develop, implement, and maintain current written medication management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse, licensed health professional, or pharmacist consistent with current practice standards and guidelines. (c) The written policies and procedures must address requesting and receiving prescriptions for medications; preparing and giving medications; verifying that prescription drugs are administered as prescribed; documenting medication management activities; controlling and storing medications; monitoring and evaluating medication use; resolving medication errors; communicating with the prescriber, pharmacist, and resident and legal and designated representatives; disposing of unused medications; and educating residents and legal and designated representatives about medications. When controlled substances are being managed, the policies and procedures must also identify how the provider will ensure security and accountability for the overall management, control, and disposition of those substances in compliance with state and federal regulations and with subdivision 23. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and maintain current	01690			

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01690	Continued From page 46 written medication management policies and procedures under the supervision and direction of a registered nurse (RN). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on December 2, 2024, at 10:00 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to residents at the facility. The licensee's provided policies lacked: - resolving medication errors. On December 5, 2024, at 9:15 a.m., CNS-B was unable to find the policy in the policy book, and stated she would see what other policies she could find and ask the chief clinical officer (CCO)-J. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01690			
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication	01730			

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01730	Continued From page 47 management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management.	01730			

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01730	Continued From page 48 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop and maintain a current individualized medication management plan for each resident to include all required content for two of two residents (R1, R2, 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: During the entrance conference on December 2, 2024, at 10:00 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to residents at the facility. R1 R1's diagnoses included altered mental state, hypertension (high blood pressure), and anxiety. R1's service plan dated June 2, 2023, indicated staff assistance for medication administration, transfers, ambulation, dressing, toileting, bathing, housekeeping and laundry. On December 3, 2024, at 7:45 a.m., the surveyor observed unlicensed personnel (ULP)-C administer R1's scheduled morning medications.	01730			

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01730	Continued From page 49 R1's medication management plan dated September 11, 2024, lacked type of medication storage system, based on resident needs. R2 R2's diagnoses included vascular dementia, hypertension, and anxiety. R2's undated service plan, indicated staff assistance for medication administration, bathing, toileting, vital sign monitoring, housekeeping and laundry. On December 3, 2024, at 7:15 a.m., the surveyor observed ULP-C administer R2's scheduled morning medications. R2's medication management plan dated August 14, 2024, lacked type of medication storage system, based on resident needs. R3 R3's diagnoses included type 2 diabetes, bipolar (mood swings) and hypertension. R3's undated service plan indicated staff assistance for medication administration, blood sugars, transfers, toileting, catheter output, dressing, bathing, vital sign monitoring, laundry and housekeeping. On December 3, 2024, at 10:45 a.m., the surveyor observed ULP-E administer R3's 11:00 a.m. scheduled medications. R3's medication management plan dated October 29, 2024, lacked type of medication storage system, based on resident needs. On December 4, 2024, at 2:05 p.m., clinical nurse	01730			

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01730	Continued From page 50 supervisor (CNS)-B stated she did not see where medications would be stored on any of the resident documents, including the service plan or medication management plan. CNS-B stated she was unaware medication storage needed to be documented. The licensee's Medication Management Individualized Plan dated December 13, 2021 indicated [facility name] assisted living will develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: a description of storage of medications based on the residents needs and preferences, risk for diversion, and consistent with the manufacturer directions. The licensee's Medication Storage policy dated December 13, 2021, indicated medications will be stored consistent with each residents medication management plan or service plan. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730			
01750 SS=F	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	01750			

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NAME OF PROVIDER OR SUPPLIER ARBOR PARK LIVING CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2921 6TH AVENUE NORTH MOORHEAD, MN 56560		
(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
01750	Continued From page 51 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 interview and record review, the licensee failed to ensure as needed (PRN) medications included parameters for administration for one of three residents (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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R3's diagnoses included type 2 diabetes, bipolar (mood swings) and hypertension. R3's undated service plan indicated staff assistance for medication administration, blood sugars, transfers, toileting, catheter output, dressing, bathing, vital sign monitoring, laundry and housekeeping. R3's electronic medication administration record (EMAR) dated December 2024, included: - acetaminophen 325 milligram (mg) Take 2 tablets by mouth every 4 hours as needed up to 3 times a daily for pain, max 4 gram/24 hours from all sources; - oxycodone 5 mg tablet Take 1 tablet by mouth	01750			

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01750	Continued From page 52 every 4 hours as needed for pain; - albuterol HFA 90 microgram (mcg)/ACT inhaler Inhale 1 puff by mouth every 6 hours as needed for shortness of breath; - Duoneb 3 mg-0.5 mg/3 milliliter (ml) Inhale 1 vial via nebulizer twice a day as needed for acute respiratory failure with hypoxia; - Nystatin 100,000 unit topical powder Apply small amount to affected area twice daily for yeast as needed; - Remedy Phylex Z Guard paste (antifungal) Apply to affected area as needed for skin irritation; and - triamcinolone 0.5% topical cream Apply to affected areas twice a day for skin irritation. R1's record lacked specific written instructions regarding the following medications: - parameters for administration of as needed pain medications in which order to administer; - parameters for administration of as needed albuterol inhaler and DuoNeb nebulizer treatment in which order to administer; and - parameters for as needed Nystatin powder, Remedy Phytplex Z Guard paste, and triamcinolone cream in which order to administer. On December 4, 2024, at 2:00 p.m., clinical nurse supervisor (CNS)-B stated there were no specific instructions for R3's as needed medications, and was unaware parameters should be added, but stated it made sense. The licensee's Delegation of Assisted Living Services policy dated December 13, 2021, indicated when medication administration is delegated to a ULP, the RN will specify in writing, specific instructions for each resident and document those instructions in the resident record.	01750			

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01750	Continued From page 53 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750			
01820 SS=F	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure current written or electronically recorded prescriptions were obtained for three of three residents (R1, R2, R3) who received medication management services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 December 2, 2024, at 10:00 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to residents at the facility.	01820			

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01820	Continued From page 54 R1 R1's diagnoses included altered mental state, hypertension (high blood pressure), and anxiety. R1's service plan dated June 2, 2023, indicated staff assistance for medication administration, transfers, ambulation, dressing, toileting, bathing, housekeeping and laundry. On December 3, 2024, at 7:45 a.m., the surveyor observed unlicensed personnel (ULP)-C administer R1's scheduled morning medications. R1's electronic medication administration record (EMAR) dated November 2024, indicated the following medications were scheduled and administered: - calcium (supplement) 600 milligram (mg), D3 10 microgram (mcg) twice daily; - daily-vite (supplement) daily; - memantine (altered mental state) 10 mg twice daily; - quetiapine (adjustment disorder) 25 mg daily; - trazodone (insomnia) 40 mg daily; - acetaminophen (pain) 325 mg every 4 hours as needed; - cough and chest (cough) dextromethorphan (DM) 5-100 mg/milliliter (ml) liquid 20 ml every 4 hours as needed; - docusate sodium (constipation) 100 mg soft gel 100 mg 2 caps once daily as needed; - loperamide (loose stools) 2 mg give 2 tabs after first diarrhea, 1 tab after second, 1 tab after third within 24 hours; - simvastatin (high cholesterol) 40 mg daily; - aspirin (hypertension) 81 mg chewable daily; and - nabumetone (pain) 500 mg twice daily.	01820			

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01820	Continued From page 55 R1's record lacked prescriber orders or medication dosage for the above medications. R2 R2's diagnoses included vascular dementia, hypertension, and anxiety. R2's undated service plan, indicated staff assistance for medication administration, bathing, toileting, vital sign monitoring, housekeeping and laundry. On December 3, 2024, at 7:15 a.m., the surveyor observed ULP-C administer R2's scheduled morning medications. R2's EMAR dated November 2024, indicated the following medications were scheduled and administered: - acetaminophen (APAP) (pain) 500 mg 2 tabs twice daily; - hydrocodone/APAP (pain) 5 mg/325 mg twice daily; - Flomax (urinary retention) 0.4 mg daily; - albuterol HFA (shortness of breath) 90 mcg/ACT 1-2 puffs by mouth as needed; - Flonase (nasal congestion) spray instill 1 spray into both nostrils as needed; - atorvastatin (high cholesterol) 80 mg daily; - olanzapine (depression) 20 mg daily; and - sertraline (depression) 100 mg daily. R2's record lacked prescriber orders or medication dosage for the above medications. R3 R3's diagnoses included type 2 diabetes, bipolar (mood swings) and hypertension. R3's undated service plan indicated staff	01820			

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01820	Continued From page 56 assistance for medication administration, blood sugars, transfers, toileting, catheter output, dressing, bathing vital sign monitoring, laundry and housekeeping. On December 3, 2024, at 10:45 a.m., the surveyor observed ULP-E administer R3's 11:00 a.m. scheduled medications. R3's EMAR dated December 2024, indicated the following medications were scheduled and administered: - cephalexin (urinary tract infection) 500 mg four times a day; - Nystatin (yeast infection) 100,000-unit powder topically twice daily; - acetaminophen (pain) 500 mg 2 tab twice daily; - bupropion (depression) 450 mg daily; - montelukast (respiratory failure)10 mg once daily; - metoprolol tartrate (high blood pressure) 50 mg twice daily; - remedy phytplex paste, Zgurd 4Z (skin irritation) apply to affected area, and as needed; - albuterol HFA (shortness of breath) 90 mcg/act 1 puff every 6 hours as needed; - DuoNeb (respiratory) 3 mg-0.5 mg/3 mg inhale vial via nebulizer twice a day as needed; - acetaminophen (pain) 325 mg 2 tabs every four hours as needed; - chest and cough DM (cough) take 10 ml every 4 hours as needed; - antacid-antigas liquid (heartburn) 10 ml every 6 hours as needed as needed; - bisacodyl (constipation) 10 mg rectal inset 1 suppository rectally once daily as needed; - calcium antacid (heartburn)750 mg three times a day; - loperamide HCl 2 mg give 2 tabs after first diarrhea, 1 tab after second, 1 tab after third	01820			

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01820	Continued From page 57 within 24 hours; and - pantoprazole (acid-reflux) 40 mg daily. R2's record lacked prescriber orders or medication dosage for the above medications. On December 4, 2024, at 2:00 p.m., CNS-B stated she did not have the prescriber orders for the above medications for R1, R2 and R3. CNS-B stated she would need to look further into the medication orders that are missing. The licensee's Medications-Prescription and Over the Counter (OTC) policy dated December 13, 2021, indicated [facility name] assisted living will require a prescription for all medications the provider manages. The facility will inform the resident of the requirement for all over the counter and dietary supplements before the facility agrees to manage those medications. The nursing staff will obtain prescribed or written orders prior to administering medications for a resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820			
01890 SS=F	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.	01890			

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01890	Continued From page 58 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure time sensitive medications included the opened on date for one of one resident (R3), failed to ensure medications had original prescription labels including the opened-on date for time sensitive medications for two of two residents (R9, R10) and failed to ensure medications had original prescription labels for three of three residents (R9, R11, R12). 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: On December 2, 2024, from 12:40 p.m. through 1:20 p.m., the surveyor toured the facility with clinical nurse supervisor (CNS)-B including a review of medication storage rooms and carts for facility identifiers (B1, B2, B3 and Aspen first floor and second floor). CNS-B stated all time-sensitive medications should be marked appropriately with open date and expiration date, and all medications should be kept with an original pharmacy label and confirmed the following medications below: TIME SENSITIVE MEDICATION R3's opened Lantus insulin 100 units/milliliter (ml) pen (a multiple dose pen shaped injector device for insulin administration) did not have a label	01890			

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01890	Continued From page 59 which indicated the date pen had been opened and when the pen would expire). Manufacturer's instructions for Lantus insulin, dated June 2022, indicated to discard the pen 28 days after it had been opened, even if it still had insulin left in it. TIME SENSITIVE MEDICATION/LACKED ORIGINAL PHARMACY LABELS R9's fluticasone propionate/salmeterol diskus (reduces swelling in the airways) 100 microgram (mcg)/50 mcg lacked original pharmacy label and opened on date. R10's budesonide/formoterol inhaler (reduces swelling in the airways) 80/4.5 mcg lacked original pharmacy label and opened on date. Manufacturer instructions for fluticasone propionate/salmeterol dated November 2024, indicated to discard after 3 months from removing from the foil. Manufacturer instructions for budesonide/formoterol inhaler dated February 2021, indicated to discard after 1 month from removing from the foil. LACKED ORIGINAL PHARMACY LABELS R9's melatonin (insomnia) 50 mcg lacked original pharmacy label. R11's fluticasone propionate nasal spray (reduces swelling in the nasal airways) 110 mcg lacked original pharmacy label. R12's diclofenac sodium topical gel 1 % (pain) and hydrocortisone cream 1% (skin irritation) lacked original pharmacy label.	01890			

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01890	Continued From page 60 The Licensee's Medication Storage policy dated December 13, 2021, indicated when the facility receives a prescription drug for immediate or later administration, the prescription drug must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including expiration or beyond use date of a time dated drug. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			
01950 SS=E	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced	01950			

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01950	Continued From page 61 by: Based on observation, interview, and record review, the licensee failed to ensure specific written instructions were documented for two of three residents (R1, R3) who received treatments. 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: R1 R1's diagnoses included altered mental state, hypertension (high blood pressure), and anxiety. On December 3, 2024, at 7:45 a.m., the surveyor observed unlicensed personnel (ULP)-C administer R1's scheduled morning medications. R1's service plan dated June 2, 2023, indicated staff assistance for medication administration, transfers, ambulation, dressing, toileting, bathing, housekeeping, and laundry. R1's electronic medication administration record (EMAR) dated November 2024, indicated compression stockings on in the morning and off at night. R1's record lacked specific written instructions to include parameters for compression hose and when to notify registered nurse (RN).	01950			

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01950	Continued From page 62 R3 R3's diagnoses included type 2 diabetes, bipolar (mood swings) and hypertension. R3's undated service plan indicated staff assistance for medication administration, blood sugars, transfers, toileting, catheter output, dressing, bathing, vital sign monitoring, laundry, and housekeeping. On December 3, 2024, at 10:45 a.m., the surveyor observed ULP-E administer R3's 11:00 a.m. scheduled medications. R3's prescriber order dated March 18, 2024, indicated blood glucose checks twice daily. R3's record lacked specific written instructions to include parameters for monitoring R3's blood sugar and when to notify the RN. On December 4, 2024, at 2:00 p.m., clinical nurse supervisor (CNS)-B stated there was not specific instructions for R1's compression stockings, or R3's blood glucose, or when to notify the RN. The licensee's Delegation of Assisted Living Services policy dated December 13, 2021 indicated when medication administration is delegated to a ULP, the RN will specify in writing, specific instructions for each resident and document those instructions in the resident record, including performing routine delegated medical or nursing procedures, such as compression stockings. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950			

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01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders 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 to ensure written or electronically recorded orders were obtained for one of three residents (R1) who had a treatment managed by the provider. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On December 2, 2024, at 10:00 a.m., during the entrance conference, clinical nurse supervisor (CNS)-B stated the licensee provided treatment services to residents. R1's diagnoses included altered mental state, hypertension (high blood pressure), and anxiety.	01970			

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NAME OF PROVIDER OR SUPPLIER ARBOR PARK LIVING CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2921 6TH AVENUE NORTH MOORHEAD, MN 56560		
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01970	Continued From page 64 On December 3, 2024, at 7:45 a.m., the surveyor observed unlicensed personnel (ULP)-C administer R1's scheduled morning medications. R1 refused to put compression stockings on. R1's service plan dated June 2, 2023, did not include compression stockings as a treatment service the resident was receiving. R1's electronic medication administration record (EMAR) dated November 2024, indicated compression stockings on in the morning and off at night. R1's record lacked prescriber orders for compression stockings. On December 4, 2024, at 2:00 p.m., CNS-B stated she was unable to find a compression stocking treatment order for R1. A treatment prescriber order policy was requested, but policy was not received. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970			
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	02040			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30361	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/06/2024
NAME OF PROVIDER OR SUPPLIER ARBOR PARK LIVING CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2921 6TH AVENUE NORTH MOORHEAD, MN 56560		
(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 65 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 safety risk assessment or hazard vulnerability assessment of the physical environment on and around the property with mitigation factors. This deficient practice had the ability to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident ' s health or safety) 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). Findings include: On December 5, 2024, a safety risk assessment or hazard vulnerability assessment for the physical environment was requested by surveyor. This assessment was not provided by the licensee. During an interview on December 5, 2024, at 4:45 p.m., office personnel (OP)-F verified a safety risk assessment or hazard vulnerability assessment with mitigation factors for the physical environment on and around the property was not available. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040			

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER ARBOR PARK LIVING CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2921 6TH AVENUE NORTH MOORHEAD, MN 56560		
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02310 SS=F	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 storage of cleaning supplies. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On December 2, 2024, at 12:40 p.m., the surveyor toured the secured unit for dementia care with clinical nurse supervisor (CNS)-B. The surveyor and CNS-B found the laundry room door open. CNS-B stated the laundry room door should always be locked. The surveyor and CNS-B observed the following chemicals within reach on the shelf above the washer and dryer: -one opened bottle of Clorox bleach disinfectant spray; -one open bottle of Windex window cleaner;	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30361	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/06/2024
NAME OF PROVIDER OR SUPPLIER ARBOR PARK LIVING CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2921 6TH AVENUE NORTH MOORHEAD, MN 56560		
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02310	Continued From page 67 -two open bottles of germicidal cleaner; -one open bottle of Resolve pet expert cleaner; -two bottles of Shout stain remover; and -one open bottle of Odoban odor control. On December 2, 2024, at 12:45 p.m., the surveyor and CNS-B found the Beauty Shop door open. CNS-B stated this door should always be locked. The surveyor and CNS-B observed the following chemicals in the room: -one can of Aqua net hair spray; -one open bottle of Clorox disinfecting wipes; -one open bottle of Edge shaving gel; -one open bottle of Pantene hair conditioner; and -one open bottle of Garnier shampoo. On December 3, at 8:20 a.m. the surveyor observed the dementia care laundry room door open with same chemicals as listed above. Unlicensed personnel (ULP)-C stated the door should be kept locked. On December 3, from 8:35 a.m., through 8:50 a.m., CNS-B stated there should be no chemicals within reach in the dementia care unit. The surveyor and CNS-B observed the following chemicals in the resident bathrooms in the dementia care unit: -R5, one open bottle of Lysol toilet bowl cleaner; -R6, open bottle of Clorox disinfecting wipes; -R2, open bottle of Clorox disinfecting wipes; -R13, open bottle of Clorox disinfecting wipes; -R1, one open bottle of Lysol toilet bowl cleaner; -R12, open bottle of Clorox disinfecting wipes; and -R8, open bottle of Clorox disinfecting wipes. The safety data sheet for Lysol toilet bowl cleaner dated October 25, 2016, indicated it was a hazardous chemical and to avoid inhalation,	02310			

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER ARBOR PARK LIVING CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2921 6TH AVENUE NORTH MOORHEAD, MN 56560		
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02310	Continued From page 68 ingestion, or contact with eyes, skin, or clothing. The safety data sheet for Clorox disinfecting wipes dated April 27, 2015, indicated it was a hazardous chemical, and to avoid inhalation, ingestion or contact with eyes and skin. The safety data sheet for Shout laundry stain remover dated November 30, 2017, indicated it was a hazardous chemical, and to avoid inhalation, ingestion or contact with eyes and skin. The safety data sheet for Odoban odor remover dated February 10, 2022, indicated it was a hazardous chemical, and to avoid inhalation, ingestion or contact with eyes and skin. The safety data sheet for Windex glass cleaner dated February 11, 2022, indicated it was a hazardous chemical, and to avoid inhalation, ingestion or contact with eyes and skin. The safety data sheet for germicidal cleaner dated October 29, 2021, indicated it was a hazardous chemical, and to avoid inhalation, ingestion or contact with eyes and skin. The safety data sheet for Resolve pet expert cleaner dated October 23, 2024, indicated it was a hazardous chemical, and to avoid inhalation, ingestion or contact with eyes and skin. The safety data sheet for Aqua net hair spray dated October 2013, indicated it was a hazardous chemical, and to avoid inhalation, ingestion or contact with eyes and skin. The safety data sheet for Edge shaving gel dated June 6, 2022, indicated it was a hazardous	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30361	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/06/2024
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02310	Continued From page 69 chemical, and to avoid inhalation, ingestion or contact with eyes and skin. The safety data sheet for Pantene conditioner dated February 5, 2014, indicated it was a hazardous chemical, and to avoid inhalation, ingestion or contact with eyes and skin. The safety data sheet Garnier shampoo dated September 27, 2004, indicated it was a hazardous chemical, and to avoid inhalation, ingestion or contact with eyes and skin. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310			



MN Department of Health
Food Pools and Lodging Services
PO Box 64975
St Paul, MN, 55164
218-332-5150

Type: Full
Date: 12/02/24
Time: 10:04:36
Report: 1042241051

Food and Beverage Establishment Inspection Report

Page 1

Location:

Arbor Park Living Center Llc
2921 6th Avenue North
Moorhead, MN56560
Clay County, 14

Establishment Info:

ID #: 0039340
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2183599999
ID #:

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

The following orders were issued during this inspection.

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment. CFPM must be employed for the establishment. Complete ServeSafe course, then submit documentation of completion with \$35 fee to MDH for CFPM certification. More info on MDH's website. WILL FOLLOW UP WITHIN 90 DAYS.

Comply By: 12/03/24

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.12A

MN Rule 4626.1520A Clean and maintain all physical facilities clean. Maintain cleanliness in all coolers, freezers, and facilities within the establishment. Corrected on site.

Comply By: 12/03/24

Surface and Equipment Sanitizers

Chlorine: = 200ppm at Degrees Fahrenheit
Location: Dishwasher Main Kitchen
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 34.5 Degrees Fahrenheit - Location: Swiss Cheese
Violation Issued: No

Type: Full
Date: 12/02/24
Time: 10:04:36
Report: 1042241051
Arbor Park Living Center Llc

Food and Beverage Establishment Inspection Report

Process/Item: Cold Holding Temperature: 35.3 Degrees Fahrenheit - Location: Bleu Cheese Violation Issued: No
Process/Item: Cold Holding Temperature: 38.3 Degrees Fahrenheit - Location: Pickles Violation Issued: No
Process/Item: Cold Holding Temperature: 38.2 Degrees Fahrenheit - Location: Ham Violation Issued: No
Process/Item: Cooking Temperature: 344 Degrees Fahrenheit - Location: Chicken Violation Issued: No
Process/Item: Walk-In Freezer Temperature: 6.0 Degrees Fahrenheit - Location: Bread Stick Violation Issued: No
Process/Item: Walk-In Freezer Temperature: 6.4 Degrees Fahrenheit - Location: Peas Violation Issued: No
Process/Item: Walk-In Cooler Temperature: 34.4 Degrees Fahrenheit - Location: Oranges Violation Issued: No
Process/Item: Walk-In Cooler Temperature: 38.2 Degrees Fahrenheit - Location: Apple Juice Violation Issued: No

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

CFPM required: Sanitarian will follow up regarding this process, providing enough time to take food safety course and submit documentation of completion to MDH. Your establishment serves at-risk groups and MUST adhere to this standard.

BUTCHER BLOCK: This block must be monitored for larger cracks and chips and removed IMMEDIATELY if any are found. These can harbor bacteria and viruses.

OUTDOOR GRILL: Any grill-out events hosted by the establishment must be done by an employee of the establishment who works in food preparation and is or is overseen by the CFPM. ALL GRILLED FOOD (Burgers, Steaks, etc.) MUST BE COOKED TO WELL-DONE.

NOTE: Meat, eggs, or other products should never be made "to order" and should always be well-done or fully cooked by FDA standards.

Type: Full
Date: 12/02/24
Time: 10:04:36
Report: 1042241051
Arbor Park Living Center Llc

Food and Beverage Establishment Inspection Report

Page 3

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the MN Department of Health inspection report number 1042241051 of 12/02/24.

Certified Food Protection Manager: _____

Certification Number: _____ Expires: ____ / ____ / ____

Signed: _____
Establishment Representative

Signed:  _____
Tyler Pyle
Environmental Health Specialist
Fergus Falls Area Office
tyler.pyle@state.mn.us