



Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF REMOVAL OF CONDITIONAL LICENSE

Electronic Delivery

June 12, 2025

Licensee

Comfort Care Assisted Living

414 East 26th Street

Minneapolis, MN 55404

RE: License Number 416765

Health Facility Identification Number (HFID) 35884

Project Number(s) SL35884015

Dear Licensee:

On June 9, 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 August 16, 2024. The follow-up survey found the facility to be in compliance. Based on these findings, the condition(s) on the license were removed effective June 12, 2025.

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.

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 'Rick Michals'.

Rick Michals, J.D.

Executive Regional Operations Manager

Minnesota Department of Health

Health Regulation Division

HHH



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

January 24, 2025

Licensee
Comfort Care Assisted Living
414 East 26th Street
Minneapolis, MN 55404

RE: Project Number(s) SL35884015

Dear Licensee:

On November 22, 2024, 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 August 16, 2024. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the August 16, 2024, survey.

MDH may assess fines based on the level and scope of the orders outlined below. The total amount of **potential** fines that may be assessed related to these correction orders is \$9,000.00. **MDH is not imposing these fines against your license at this time.**

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on August 16, 2024, found not corrected at the time of the November 22, 2024, follow-up survey and/or subject to penalty assessment are as follows:

1750-Delegation Of Medication Administration-144g.71 Subd. 7 - \$3,000.00
1760-Documentation Of Administration Of Medication-144g.71 Subd. 8 - \$3,000.00
1820-Prescriptions-144g.71 Subd. 13

The details of the violations noted at the time of this follow-up survey completed on November 22, 2024 (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 November 22, 2024, we identified the following violation(s):

0340-Correction Orders-144g.30 Subd. 5 - \$3,000.00
0495-Minimum Requirements-144g.41 Subdivision. 1 (13)
1400-Availability Of Contact Person To Staff-144g.62 Subdivision 1
1960-Documentation Of Administration Of Treatments-144g.72 Subd. 5
2320-Appropriate Care And Services-144g.91 Subd. 4 (b)

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.

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.

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. **If corrections are not made, MDH may impose fines as described above and in accordance with Minnesota Statutes 144G.**

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.

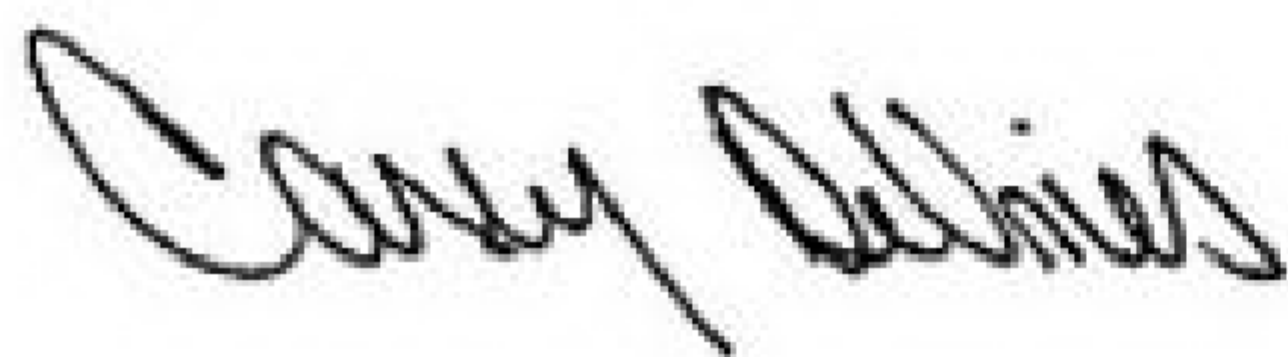
INFORMAL CONFERENCE

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 Comfort Care Assisted Living. Please contact Casey DeVries, at 651-201-5917 **on or before Wednesday, January 29, 2025**, to schedule the conference call.

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

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

Sincerely,

A handwritten signature in black ink that reads "Casey DeVries". The signature is written in a cursive, flowing style.

Casey DeVries, Supervisor
State Evaluation Team
Email: Casey.DeVries@state.mn.us
Telephone: 651-201-5917 Fax: 1-800-337-9238

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35884	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 11/22/2024
NAME OF PROVIDER OR SUPPLIER COMFORT CARE ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 414 EAST 26TH STREET MINNEAPOLIS, MN 55404			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
{0 000}	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL35884015-1 On November 19, 2024, through November 22, 2024, the Minnesota Department of Health conducted a licensing order follow up survey at the above provider, and the following correction orders are issued. At the time of the survey, there were three residents, all of whom received services under the Assisted Living license.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.		
0 340 SS=I	144G.30 Subd. 5 Correction orders (a) A correction order may be issued whenever the commissioner finds upon survey or during a	0 340			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 340	Continued From page 1 complaint investigation that a facility, a managerial official, an agent of the facility, or staff of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail or email copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must: (1) document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have sufficient documentation with actions taken to comply with the correction orders for a survey completed on August 16, 2024. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that	0 340			

Minnesota Department of Health

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0 340	Continued From page 2 has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 16, 2024, the Minnesota Department of Health completed a survey resulting in 22 correction orders issued. The immediacy of order with tag identification 1760 was not removed prior to survey exit on August 16, 2024. On November 19, 2024, at approximately 12:19 p.m., the surveyor inquired if clinical nurse supervisor (CNS)-C was aware of the correction orders issued related to medication management upon the initial survey. CNS-C stated, "no they did not tell me." On November 20, 2024, at 12:40 p.m., CNS-C stated they were hired by the licensee in February 2024, they worked for two weeks and had to leave for an emergency. CNS-C stated they were rehired couple months ago; they did not know the exact date. On November 20, 2024, at approximately 2:30 p.m., via telephone, the surveyor inquired with agent (A)-G if they could provide their plan of correction for correction orders issued following the survey completed on August 16, 2024. A-G stated they already sent a plan of correction to the surveyor's supervisor. The surveyor explained the plan of correction that was sent to the surveyor's supervisor was only for the immediate orders and inquired if they had plan of correction for all other orders issued. A-G stated they would contact the licensed assisted living director ((LALD)-D) and provide the plan of correction via	0 340			

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0 340	Continued From page 3 email. On November 21, 2024, at 11:53 a.m., via email correspondence, A-G indicated, "we are unable to send you the POC as you requested because the Director who was assigned to work on the correction is currently out of the country, and we are trying to get hold of [LALD-D]." A-G also inquired, "If you can give us a few days extension while we work on this, that'll be super helpful." On November 21, 2024, at 1:42 p.m., the surveyor attempted to reach LALD-D and was unable to reach the LALD or leave a voice message as the voice message inbox was full and could not accept messages. The follow up survey was completed on November 22, 2024. Upon completion, the surveyor found the licensee was not in compliance with three correction orders previously issued following the initial survey, delivered via email to the licensee on October 3, 2024, tags identified as 1750 and 1760, both level three violations, and 1820, a level two violation. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 340			
{0 470} SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet	{0 470}			

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{0 470}	Continued From page 4 the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by:	{0 470}	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	{0 480}			

Minnesota Department of Health

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{0 480}	Continued From page 5 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, 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	{0 480}			

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{0 480}	Continued From page 6 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}	Not reviewed during this survey.		
0 495 SS=F	144G.41 Subdivision. 1 (13) Minimum Requirements (13) provide staff access to an on-call registered nurse 24 hours per day, seven days per week. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure clinical nurse supervisor (CNS)-C's phone number was readily available for staff performing delegated nursing tasks and services. This had the potential to affect all residents and staff of the facility. The licensee hired CNS-C to perform all nursing tasks and to provide oversight to unlicensed personnel (ULP). 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 Employee List provided to the surveyor on November 20, 2024, at 9:20 a.m., via email	0 495			

Minnesota Department of Health

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0 495	Continued From page 7 correspondence, indicated CNS-C was hired on February 13, 2024. On November 20, 2024, at approximately 9:50 a.m., the surveyor inquired if ULP-A had reported R1's high blood sugar results taken during their shifts to the CNS. ULP-A stated they did not call the CNS because they did not have CNS-C's number. On November 20, 2024, at 10:27 a.m., the surveyor referred to blood glucose test results printed from Rtask (charting software) and inquired if CNS-C was aware of the high blood sugar results ranging from 300 to 548 on multiple occasions for the period of November 1 through November 19, 2024. CNS-C stated they were not notified about any of the high blood sugars noted on the report. On November 20, 2024, at 11:52 a.m., the surveyor observed no postings with CNS-C's phone number. ULP-A pointed to a wall posting in the living room with the previous nurse's phone number and stated they did not have the new nurse's phone number posted anywhere. ULP-A stated they got the new nurse's phone number from housing manger/unlicensed personal (HM/ULP)-B yesterday, November 19, 2024, and had saved the number in their phone. On November 20, 2024, at 12:40 p.m., CNS-C stated they were hired by the licensee in February 2024, they worked for two weeks and had to leave for an emergency. CNS-C stated they were rehired couple months ago; they did not know the exact date. On November 22, 2024, at 9:58 a.m., ULP-A stated they were trained to call the nurse when	0 495			

Minnesota Department of Health

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0 495	Continued From page 8 blood sugars were over three hundred or below seventy by the previous nurse. ULP-A stated they called HM/ULP-B when blood sugars where high since they did not have the new nurse's phone number. On November 22, 2024, at approximately 10:05 a.m., HM/ULP-B stated they did not know the ULPs did not have the CNS' phone number, and they forgot to update the postings with new nurse's phone number; the director was supposed to change it. HM/ULP-B stated, "It is not a big deal we can just cross off [the previous nurse's] name and put [the new nurse's] name. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 495			
{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 infomation: (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	{0 650}			

Minnesota Department of Health

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{0 650}	Continued From page 9 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. This MN Requirement is not met as evidenced by:	{0 650}	Not reviewed during this survey.		
{0 660} SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by:	{0 660}			
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness	{0 680}	Not reviewed during this survey.		

Minnesota Department of Health

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{0 680}	Continued From page 10 (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:	{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	{0 780}	Not reviewed during this survey.		

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

**414 EAST 26TH STREET
MINNEAPOLIS, MN 55404**

(X4) ID
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**SUMMARY STATEMENT OF DEFICIENCIES
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PROVIDER'S PLAN OF CORRECTION
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DEFICIENCY)

(X5)
COMPLETE
DATE

 $\{0\ 780\}$

Continued From page 11

 $\{0\ 780\}$

- 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:

Not reviewed during this survey.

$$\{0 \ 800\}$$
$$SS=F$$

144G.45 Subd. 2 (a) (4) Fire protection and physical environment

 $\{0 \ 800\}$

(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:

Not reviewed during this survey.

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{0 950}	Continued From page 13	{0 950}	Not reviewed during this survey.		
{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 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:				
{01060} SS=F	144G.52 Subd. 9 Emergency relocation	{01060}			

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{01060}	Continued From page 14 (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's	{01060}			

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{01060}	Continued From page 15 refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: 01400 SS=F 144G.62 Subdivision 1 Availability of contact person to staff (b) The appropriate contact person must be readily available either in person, by telephone, or by other means to the staff at times when the staff is providing services. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure staff had access to licensed assisted living director (LALD)-D due to the director being out of the country. 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: LALD-D started at the licensee April 1, 2024. On November 19, 2024, at 8:30 a.m., during a phone call, housing manager/unlicensed	{01060}	Not reviewed during this survey.		
		01400			

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01400	Continued From page 16 personnel (HM/ULP)-B stated LALD-D was in Africa for a funeral. Upon entering the licensee on November 19, 2024, at 10:00 a.m., owner/unlicensed personnel (O/ULP)-H reached LALD-D by phone. O/ULP-H stated LALD-D was aware of the survey and they could be reached by phone at any time. On November 20, 2024, at approximately 2:45 p.m., HM/ULP-B attempted to reach LALD-D but was unable to get ahold of them.. On November 21, 2024, at 11:53 a.m., via email correspondence, agent (A)-G indicated, "we are unable to send you the POC [plan of correction] as you requested because the Director who was assigned to work on the correction is currently out of the country, and we are trying to get hold of [LALD-D]." On November 21, 2024, at 1:42 p.m., the surveyor again attempted to reach LALD-D and was unable to reach the LALD or leave a voice message as the voice message inbox was full and could not accept messages. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01400			
{01500} SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the	{01500}			

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{01500}	Continued From page 17 provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and	{01500}			

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{01500}	Continued From page 18 challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by:	{01500}	Not reviewed during this survey.		
{01530} SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor	{01530}			

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{01530}	Continued From page 19 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:	{01530}	Not reviewed during this survey.		
{01610} SS=E	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. This MN Requirement is not met as evidenced by:	{01610}			
{01620} SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring	{01620}	Not reviewed during this survey.		

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{01620}	Continued From page 20 (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by:	{01620}			
{01640} SS=E	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting	{01640}	Not reviewed during this survey.		

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{01640}	Continued From page 21 agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by:	{01640}	Not reviewed during this survey.		
{01750} SS=G	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by:	{01750}			

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{01750}	Continued From page 22 Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) prepared in writing specific medication administration instructions related to insulin for one of one resident (R1). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On August 15, 2024, at 2:40 p.m., during the initial survey, the former clinical nurse supervisor (CNS) stated they used two different pharmacies for R1's medication supply; they got NovoLog from [pharmacy #1] and Lantus and all oral meds from [pharmacy #2]. R1 was admitted to the facility on October 31, 2023. R1's diagnoses included schizoaffective disorder, cannabis use disorder, intellectual disability post-traumatic stress disorder schizophrenia, diabetes mellitus, hypertension, hyperlipidemia, history of malnutrition, and personality disorder. R1's service plan dated July 29, 2024, included the following services: insulin injections by the home health aide/resident assistant (HHA/RA) three times per day, medication administration by the HHA/RA three time per day, record-blood glucose (BG) by the HHA/RA three time per day, and supervision of the blood glucose record by	{01750}			

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{01750}	Continued From page 23 the RN one day a week. R1's Master Care Plan dated November 20, 2024, indicated the following: - "[R1] has been diagnosed with Type 1 diabetes and is supposed to take insulin with any food. [R1] does not always do so and has a history of poor glucose control Stating [sic] [R1's] readings used to be regularly in the 300's but recently have been in the 100's. [R1] checks [their] blood sugar at least twice a day and is very resistive to staff with reminders and assistance with BS [blood sugar] checks. Staff will continue to provide reminders and assistance to take [their] insulin as per MD [medical doctor] orders and to eat healthy. Staff will report any low or high blood sugar readings to RN immediately and call 911 with any emergencies." - R1 was at risk for self-neglect and R1's mental health impacted R1's ability to take their medication as prescribed. R1 became upset and argumentative with staff when discussing the need to follow providers orders; staff will remain calm; provide education to R1 and notify the nurse with any concerns; - R1 needed full medication management and setup; RN will be responsible for medication management, medication setup/ reconciliation with providers and pharmacy as ordered by the physician; - RN will review/clarify any medication instructions from the physician that are not clear; and - R1 needs frequent dosage changes or review of lab tests-blood glucose. R1's record included an unsigned After Visit Summary (AVS) dated October 9, 2024, from a Diabetic and Endocrinology Clinic which indicated:	{01750}			

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{01750}	Continued From page 24 - Insulin aspart (fast-acting insulin) (NovoLog) 100units/mL FlexPen inject 6 units (u) subcutaneously three times daily after meal and 4u with small meals/snack. Do not take if not eating. TDD (total daily dose) 35u daily. R1's Medication Administration Record (MAR) dated November 2024, indicated: - Insulin aspart (fast-acting insulin) (NovoLog) 100units/mL FlexPen inject 6u subcutaneously three times daily after meal. For safety reasons do not take if not eating. Notify RN with any questions. R1's NovoLog insulin directions on the MAR dated November 2024, did not match with the AVS dated October 9, 2024. On November 19, 2024, at 12:11p.m., CNS-C stated they did not have signed physician orders for R1, "it was misplaced." On November 19, 2024, at 12:19 p.m., the surveyor referred to the AVS mentioned above and inquired about the NovoLog order. CNS-C stated, "so her insulin goes up and down they told me to give her six units after meals, I do not know about the four units." CNS-C stated, "I am new here, I am learning." CNS-C stated they did not think the order on the AVS was the right order, and the right order was misplaced. The surveyor inquired if CNS-C was aware of the correction orders issued related to medication management upon the initial survey. CNS-C stated, "no they did not tell me." On November 19, 2024, at 12:25 p.m., housing manager/unlicensed personal (HM/ULP)-B stated R1 gets 4u for snacks because R1 eats a lot of candy, but HM/ULP-B stated they did not chart it.	{01750}			

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{01750}	Continued From page 25 CNS-C who was seated at the same table with the surveyor spoke to HM/ULP-B in different language and interrupted the interview. HM/ULP-B then stated they charted it under as needed (PRN) medications. The surveyor inquired how they charted under PRN when it was not included on the MAR. HM/ULP-B stated, "No, PRN?" On November 19, 2024, at 12:30 p.m., the surveyor observed CNS-C call pharmacy #2. CNS-C put them on a speaker phone, and the surveyor heard a pharmacist from pharmacy #2 state R1's medication orders on file included the following: - Insulin aspart (fast-acting insulin) (NovoLog) 100units/mL FlexPen inject 6u subcutaneously three times daily, written on August 22, 2024. CNS-C requested a copy of all R1's medication orders from pharmacy #2. On November 19, 2024, at 1:50 p.m., unlicensed personnel (ULP)-A stated they used to give the additional 4u of NovoLog, but since the last survey they only administered 6u of NovoLog. R1's insulin administration record for AM (morning shift) indicated staff documented R1 received NovoLog at times varying from 7:28 a.m., to 2:29 p.m., PM (afternoon shift) administration times indicated staff documented R1 received NovoLog insulin at times varying from 11:56 a.m., to 5:10 p.m., and NOC (night shift) administration times indicated staff documented R1 received NovoLog insulin at times varying from 1:22 a.m., to 8:29 p.m. On November 20, 2024, at approximately 9:50 a.m., the surveyor asked ULP-A to explain their understanding of administration time frames	{01750}			

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{01750}	Continued From page 26 noted on the insulin administration record for AM, PM, and NOC shifts. ULP-A stated AM was from 7:00 a.m., to 3:00 p.m., PM was from 3:00 p.m., to 11:00 p.m., and NOC was from 11:00 p.m., to 7:00 a.m. ULP-A stated R1 did not have a set time for breakfast, lunch, or dinner, as sometimes they would get up at 5:00 a.m., sometimes at 8:00 a.m., or 9:00 a.m., and R1 refused blood sugar checks until they were up and out of their room, although, if R1 slept in very late, they would knock on R1's door to do blood sugar checks. ULP-A stated if R1were to keep refusing and it was the end of their shift, they would write decline on the MAR. On November 20, 2024, at approximately 8:30 a.m., HM/ULP-B provided the surveyor with copies of R1's E-script records received from pharmacy #1 and pharmacy #2. R1's E-Script New Prescription Request received from pharmacy #2, indicated: - Insulin aspart (fast-acting insulin) (NovoLog) 100units/mL FlexPen inject 6u subcutaneously three times daily after meals, with a start date of August 22, 2024. R1's E-Script New Prescription Request received from pharmacy #1, indicated: - Insulin aspart (fast-acting insulin) (NovoLog) 100units/mL FlexPen inject 6u subcutaneously three times daily after meal and 4u with small meals/snack. Do not take if not eating. TDD 35u daily, with a start date of September 13, 2024. The most current order for R1's NovoLog insulin was from pharmacy #1. On November 20, 2024, at approximately 10:00 a.m., CNS-C stated they did not know anything about the above-mentioned NovoLog order	{01750}			

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{01750}	Continued From page 27 received from pharmacy #1. On November 20, 2024, at approximately 10:05 a.m., the surveyor asked CNS-C to explain the AM, PM, and NOC insulin administration time frames. CNS-C stated AM was 7:00 a.m., to 8:00 a.m., PM was 11:00 a.m., to 2:00 p.m., and NOC was 6:00 p.m., to 8:00 p.m. CNS-C stated, "Their [licensee's] computer system is a little weird. I do not know their system; you are asking the wrong person." CNS-C also stated R1 eats whenever they want; they get insulin only if they eat. R1's MAR indicated R1 received the following: - NovoLog 6u on November 3, at 12:52 a.m., recorded under the NOC administration time frame; and - NovoLog 6u on November 3, at 1:38 a.m., recorded under the PM administration time frame. On November 20, 2024, at approximately 10:20 a.m., the surveyor referred CNS-C to the above noted MAR entries and inquired if R1 received two administrations of 6u of NovoLog within 50 minutes of one another. CNS-C stated "how did the computer let them [the ULPs] do that unless they charted late. They never do that the computer will not allow them." On November 20, 2024, at approximately 10:40 a.m., HM/ULP-B informed the surveyor R1 was awake, their blood glucose check was done, and R1 was eating breakfast. The surveyor asked HM/ULP-B if R1 would get insulin after they ate, and inquired if R1 ate lunch at noon would they still get insulin after? HM/ULP-B stated "If she eats at noon, we will give it [referring to the NovoLog] but she does not usually do that. How is she gonna eat at 11 and 12?" HM/ULP-B stated, "she will eat around 2:00 p.m., or 3:00, or	{01750}			

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{01750}	Continued From page 28 4:00 p.m., then she gets it; she is all over the place. It is hard to explain it, but she eats whenever she wants." On November 20, 2024, at approximately 11:05 a.m., the surveyor contacted ULP-E via phone and inquired about the November 3, 2024, 1:38 a.m., NovoLog administration indicated on the MAR. ULP-E stated, "The daylight-saving day, yes, I worked NOC shift. I think she cooked food around midnight, and I gave her insulin after she ate, I think she ate sausage. I give it to her after she ate, and I check blood sugar." ULP-E then clarified they checked blood sugars before R1 ate. The surveyor inquired if ULP-E administered insulin to R1 anytime they ate, or did they only administer at breakfast, lunch, and dinner times. ULP-E stated "I give it every time she eats. So, she is very selective, she eats whenever she wants to. She does not follow [a] schedule." The surveyor referred to the MAR and stated that NovoLog 6u was administered on November 3, 2024, at 12:52 a.m., by ULP-F and inquired if ULP-F had worked with them the night of November 3 and if ULP-E was aware R1 got NovoLog at 12:52 a.m. ULP-E stated, "Yes, [ULP-F] was with me that night." "So, what she does is, she would drink juice or eat something sugary and force staff to give her insulin; maybe that is what happened. I do not remember exactly. She did eat [a] meal for me. She called cops on [ULP-F] before, for not giving her insulin even though she did not eat." ULP-E stated R1 gets six units with a meal. The surveyor inquired if ULP-E ever gives R1 four units of insulin. ULP-E stated R1 gets four units when they drink juice or eat small snack. The surveyor inquired where the four units were charted. ULP-E stated, "It is the same charting, so it is like under the ... the thing is, we use to chart it under PRN [as	{01750}			

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{01750}	Continued From page 29 needed], now they changed it." ULP-E stated, the doctor changed the four units to six units four times a day, for breakfast, lunch, dinner, and midnight. ULP-E stated R1 forces staff to give them an additional four units. ULP-E stated they sometimes do not give it to R1. On November 20, 2024, at approximately 12:05 p.m., CNS-C stated they were not aware R1 was getting insulin four times a day, they were not aware R1 was getting insulin at midnight, and they were also not aware R1 was getting insulin after snacks. CNS-C stated, "[R1] is alert and oriented, whatever she asks she gets, if it is on the schedule." CNS-C stated insulin administration times should be eight hours apart. On November 20, 2024, at 12:29 p.m., the surveyor inquired how would the ULPs know they have to give insulin eight hours apart. CNS-C stated, "Because they know she gets it three times a day." "It is three times a day. If she wakes up at 7am she eats and she gets her insulin; if she eats lunch around one or two [pm], she gets it after she eats and then for dinner if she eats at nine, ten or eleven [pm] they [ULPs] give it to her after she eats; it is her choice." On November 20, 2024, at 12:40 p.m., CNS-C stated they were hired by the licensee in February 2024, they worked for two weeks and had to leave for an emergency. CNS-C stated they were rehired a couple of months ago; they did not know the exact date. The Employee List provided to the surveyor on November 20, 2024, at 9:20 a.m., via email correspondence, indicated CNS-C was hired on February 13, 2024. On November 20, 2024, at 12:43 p.m., CNS-C stated R1 gets insulin three times a day, if R1	{01750}			

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{01750}	Continued From page 30 eats at midnight R1 will get insulin at midnight as long as it is eight hours apart. CNS-C stated they asked the ULPs who administered insulin on November 3, 2024, at 12:52 a.m., and 1:38 a.m., and the ULPs said they gave it on time and charted late. The surveyor inquired how the ULPs would know if it was charted late, and how would they know what time the insulin was given to determine the next administration time. CNS-C stated the ULPs get a report from the previous ULP, and the ULPs did not always write a progress note. The surveyor stated to CNS-C that ULP-E and ULP-F worked NOC shift together on November 3, 2024. CNS-C stated, "No they did not." The surveyor informed the CNS that they interviewed the ULPs and learned both ULPs were on duty the night of November 3, 2024. CNS-C then stated, "so they [referring to ULPs] gave the same medication? No, they charted late, one of them charted late." CNS-C stated they did not see any problem with charting late. R1's records that were available to ULP did not reflect clear instructions for R1's insulin administration. CNS-C did not have awareness of R1's current insulin orders, was not aware ULP were administering insulin doses above and beyond what the MAR indicated, and had not written clear instructions for the ULP for how long to wait between doses insulin, nor did they ensure ULP were accurately documenting the administration times to determine when it was safe to administer the next dose of insulin. The record did not provide direction on the cut off times for AM, PM, and NOC insulin administration or provide resident-specific instructions for when R1 skipped a meal period or demanded extra insulin. The licensee's Prescriber's Orders policy dated	{01750}			

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{01750}	Continued From page 31 May 2, 2020, read, "1. Written orders from an authorized prescriber will be obtained for all medications and treatments with which the home health [the licensee's name] Assisted Living assists clients, including over the counter medications. 2. Verbal orders may be accepted by a nurse who records and signs the order and then forwards it to the prescriber for signature no later than seven days after receipt of the verbal order. 3. Telephone, facsimile, or computer-generated orders will be kept confidential. An order received by facsimile must have been signed by the prescriber and a durable copy placed in the clinical record by home care staff. 4. All orders must be signed and dated by the prescriber. If the prescriber omitted a date, the [licensee's name] Assisted Living will date the order when received from the prescriber. 5. Medication orders will include the name of the medication, dosage, and directions for use. 6. The Registered Nurse is responsible for implementing medication and treatment orders or for delegating the orders to the appropriate paraprofessional. 7. Medication and treatment orders will be renewed at least every year or when changes occur." No further information was provided.	{01750}			
{01760} SS=G	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation	{01760}			

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{01760}	Continued From page 32 must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to administer medications according to provider's orders, failed to reconcile provider's orders when changes were made, and failed to ensure staff accurately administered insulin and documented the insulin administration in accordance with the resident's medication management plan. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at 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: TRANSCRIPTION/CLARIFICATION OF PROVIDER ORDERS On August 15, 2024, at 2:40 p.m., during the initial survey, the former clinical nurse supervisor (CNS) stated they used two different pharmacies for R1's medication supply; they got NovoLog	{01760}			

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{01760}	Continued From page 33 from [pharmacy #1] and Lantus and all oral meds from [pharmacy #2]. R1 was admitted to the facility on October 31, 2023. R1's diagnoses included schizoaffective disorder, cannabis use disorder, intellectual disability post-traumatic stress disorder schizophrenia, diabetes mellitus, hypertension, hyperlipidemia, history of malnutrition, and personality disorder. R1's service plan dated July 29, 2024, included the following services: insulin injections by the home health aide/resident assistant (HHA/RA) three times per day, medication administration by the HHA/RA three time per day, record-blood glucose (BG) by the HHA/RA three time per day, and supervision of the blood glucose record by the registered nurse (RN) one day a week. R1's Master Care Plan dated November 20, 2024, included the following services: medication administration, diabetes management, RN consultation to clarify instruction changes from medical providers, and needs frequent dosage changes or review of lab tests- blood sugar. R1's 90-day assessment dated November 20, 2024, included the following related to R1's medication management: - Medication Administration- Staff will assist with reminder, administering, and documenting medications as prescribed by medical providers. - Medication Management- The RN would be responsible for medication management and medication set up/reconciliation with providers and pharmacy as ordered by the prescriber. The RN would review/clarify any medication instructions from the prescriber that were not clear.	{01760}			

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{01760}	Continued From page 34 R1's record included an unsigned After Visit Summary (AVS) dated October 9, 2024, from a Diabetic and Endocrinology Clinic which indicated: - Insulin aspart (fast-acting insulin) (NovoLog) 100units/mL FlexPen inject 6 units (u) subcutaneously three times daily after meal and 4 units with small meals/snack. Do not take if not eating. TDD (total daily dose)35 units daily. - Hydroxyzine 25milligrams (mg) tablet. Take 1 -2 tablets (25-50mg) by mouth three times daily as needed (PRN) for anxiety. - Docusate sodium -sennosides 50-8.6 mg tablet. Take 1 tablet by mouth twice daily. R1's E-Script from pharmacy #2 indicated the following orders: - Insulin aspart (fast-acting insulin) (NovoLog) 100units/mL FlexPen inject 6u subcutaneously three times daily after meals, with a start date of August 22, 2024. - Hydroxyzine HCL 50mg oral tablet. Take 1 tablet (50mg) by mouth 4 times daily with a start date of November 1, 2024. - Docusate sodium -sennosides 50-8.6 mg tablet. Take 1 tablet by mouth twice daily, with a start date of November 8, 2024. R1's E-Script from pharmacy #1 indicated the following orders: - Insulin aspart (fast-acting insulin) (NovoLog) 100units/mL FlexPen inject 6u subcutaneously three times daily after meal and 4 units with small meals/snack. Do not take if not eating. TDD 35 units daily, with a start date of September 13, 2024. R1's medication administration record (MAR) dated November 2024, included the following:	{01760}			

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{01760}	Continued From page 35 - Hydroxyzine HCL 50mg oral tablet. Take 1 tablet (50mg) by mouth 4 times daily with a start date of November 19, 2024. - Docusate sodium -sennosides 50-8.6 mg tablet. Take 1 tablet by mouth twice daily, with a start date of November 19, 2024. - Insulin aspart (fast-acting insulin) (NovoLog) 100units/mL FlexPen inject 6u subcutaneously three times daily after meal. For safety reasons do not take if not eating. Notify RN with any questions. The NovoLog insulin order on R1's MAR dated November 2024, did not match with the AVS dated October 9, 2024, or the most recent physician order written on September 13, 2024. The hydroxyzine HCL 50mg and docusate sodium -sennosides 50-8.6mg orders, although written with a start date of November 1, 2024, and November 8, 2024, respectively, were not transcribed to the MAR until November 19, 2024, during the survey. On November 19, 2024, at 12:11p.m., CNS-C stated most of the time the pharmacy transcribed medication orders into the system and the CNS confirmed the orders to be available in the system for the unlicensed personnel (ULP) to administer. CNS-C stated they had previously called the providers and requested for R1's hydroxyzine PRN order to be changed from PRN to scheduled as R1 had been receiving the medication daily. CNS-C stated they entered the hydroxyzine order into the system and that the NovoLog order was entered into the system before the CNS started working for the licensee. CNS-C also stated they did not have the signed physician orders for R1 prior to the start of the survey, "it was misplaced." On November 19, 2024, at 12:19 p.m., the	{01760}			

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{01760}	Continued From page 36 surveyor referred to the AVS mentioned above and inquired about the NovoLog order. CNS-C stated, "so her insulin goes up and down they told me to give her six units after meals, I do not know about the four units." CNS-C stated, "I am new here, I am learning." CNS-C stated they did not think the order on the AVS was the right order, and the right order was misplaced. The surveyor inquired if CNS-C was aware of the correction orders issued related to medication management upon the initial survey. CNS-C stated, "no they did not tell me." On November 19, 2024, at approximately 12:40 p.m., the surveyor inquired why the order for hydroxyzine was not entered into the system until today, November 19, 2024. CNS-C stated pharmacy did not deliver the medication. CNS-C also stated they confirmed the order for senna today, "I saw it under orders to confirm today, and I called the pharmacy and the provider then I confirmed it in the system." On November 19, 2024, at 12:43 p.m., the surveyor observed a pharmacy Delivery Manifest dated September 13, 2024, which indicated 90 tablets of hydroxyzine 25mg tablets were delivered to the licensee's address for R1. On November 19, 2024, at 12:58 p.m., the surveyor observed R1's pharmacy prepackaged medication bubble packs dispensed on November 15, 2024. The bubble packs included: - hydroxyzine Hcl 50mg in four slots for Morning, Noon, Evening, and Bedtime administration times; - Senna-plus 8.6-50mg in two slots or Morning and Bedtime administration times. On November 19, 2024, at 1:48 p.m., CNS-C	{01760}			

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{01760}	Continued From page 37 stated they entered the hydroxyzine order late because they were not notified until today, November 19, 2024. "I do not know the system. I know there was change in medication, they had it for the PRN I guess, I do not know." On November 19, 2024, at 1:50 p.m., unlicensed personnel (ULP)-A stated they used to give four units before but after the last survey they only administered six units of insulin. ULP-A also stated they check blood sugars once on their shift. INSULIN ADMINISTRATION TIMES R1's insulin administration record for AM (morning shift) indicated staff documented R1 received NovoLog at times varying from 7:28 a.m., to 2:29 p.m., PM (afternoon shift) administration times indicated staff documented R1 received NovoLog insulin at times varying from 11:56 a.m., to 5:10 p.m., and NOC (night shift) administration times indicated staff documented R1 received NovoLog insulin at times varying from 1:22 a.m., to 8:29 p.m. On November 20, 2024, at approximately 9:50 a.m., the surveyor asked ULP-A to explain their understanding of administration time frames noted on the insulin administration record for AM, PM, and NOC shifts. ULP-A stated AM was from 7:00 a.m., to 3:00 p.m., PM was from 3:00 p.m., to 11:00 p.m., and NOC was from 11:00 p.m., to 7:00 a.m. ULP-A stated R1 did not have a set time for breakfast, lunch, or dinner, as sometimes they would get up at 5:00 a.m., sometimes at 8:00 a.m., or 9:00 a.m., and R1 refused blood sugar checks until they were up and out of their room, although, if R1 slept in very late, they would knock on R1's door to do blood sugar checks.	{01760}			

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{01760}	Continued From page 38 ULP-A stated if R1were to keep refusing and it was the end of their shift, they would write decline on the MAR. On November 20, 2024, at approximately 10:00 a.m., CNS-C stated they did not know anything about the above-mentioned NovoLog orders received from pharmacy #1. On November 20, 2024, at approximately 10:05 a.m., the surveyor asked CNS-C to explain the AM, PM, and NOC insulin administration time frames. CNS-C stated AM was 7:00 a.m., to 8:00 a.m., PM was 11:00 a.m., to 2:00 p.m., and NOC was 6:00 p.m., to 8:00 p.m. CNS-C stated, "Their [licensee's] computer system is a little weird. I do not know their system; you are asking the wrong person." CNS-C also stated R1 eats whenever they want; they get insulin only if they eat. R1's MAR indicated R1 received the following: - NovoLog 6 units on November 3, at 12:52 a.m., recorded under the NOC administration time frame; and - NovoLog 6 units on November 3, at 1:38 a.m., recorded under the PM administration time frame. On November 20, 2024, at approximately 10:20 a.m., the surveyor referred CNS-C to the above noted MAR entries and inquired if R1 received two administrations of 6u of NovoLog within 50 minutes of one another. CNS-C stated "how did the computer let them [the ULPs] do that unless they charted late. They never do that the computer will not allow them." On November 20, 2024, at approximately 10:40 a.m., HM/ULP-B informed the surveyor R1 was awake, their blood glucose check was done, and	{01760}			

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{01760}	Continued From page 39 R1 was eating breakfast. The surveyor asked HM/ULP-B if R1 would get insulin after they ate, and inquired if R1 ate lunch at noon would they still get insulin after? HM/ULP-B stated "If she eats at noon, we will give it [referring to the NovoLog] but she does not usually do that. How is she gonna eat at 11 and 12?" HM/ULP-B stated, "she will eat around 2:00 p.m., or 3:00, or 4:00 p.m., then she gets it; she is all over the place. It is hard to explain it, but she eats whenever she wants." On November 20, 2024, at approximately 11:05 a.m., the surveyor contacted ULP-E via phone and inquired about the November 3, 2024, 1:38 a.m., NovoLog administration indicated on the MAR. ULP-E stated, "The daylight-saving day, yes, I worked NOC shift. I think she cooked food around midnight, and I gave her insulin after she ate, I think she ate sausage. I give it to her after she ate, and I check blood sugar." ULP-E then clarified they checked blood sugars before R1 ate. The surveyor inquired if ULP-E administered insulin to R1 anytime they ate, or did they only administer at breakfast, lunch, and dinner times. ULP-E stated "I give it every time she eats. So, she is very selective, she eats whenever she wants to. She does not follow [a] schedule." The surveyor referred to the MAR and stated that NovoLog 6u was administered on November 3, 2024, at 12:52 a.m., by ULP-F and inquired if ULP-F had worked with them the night of November 3 and if ULP-E was aware R1 got NovoLog at 12:52 a.m. ULP-E stated, "Yes, [ULP-F] was with me that night." "So, what she does is she would drink juice or eat something sugary and force staff to give her insulin; maybe that is what happened. I do not remember exactly. She did eat [a] meal for me. She called cops on [ULP-F] before, for not giving her insulin	{01760}			

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{01760}	Continued From page 40 even though she did not eat." ULP-E stated R1 gets six units with a meal. The surveyor inquired if ULP-E ever gives R1 four units of insulin. ULP-E stated R1 gets four units when they drink juice or eat small snack. The surveyor inquired where the four units were charted. ULP-E stated, "It is the same charting, so it is like under the ... the thing is, we use to chart it under PRN [as needed], now they changed it." ULP-E stated, the doctor changed the four units to six units four times a day, for breakfast, lunch, dinner, and midnight. ULP-E stated R1 forces staff to give them an additional four units. ULP-E stated they sometimes do not give it to R1. On November 20, 2024, at approximately 12:05 p.m., CNS-C stated they were not aware R1 was getting insulin four times a day, they were not aware R1 was getting insulin at midnight, and they were also not aware R1 was getting insulin after snacks. CNS-C stated, "[R1] is alert and oriented, whatever she asks she gets, if it is on the schedule." CNS-C stated insulin administration times should be eight hours apart. On November 20, 2024, at 12:29 p.m., the surveyor inquired how would the ULPs know they have to give insulin eight hours apart. CNS-C stated, "Because they know she gets it three times a day." "It is three times a day. If she wakes up at 7am she eats and she gets her insulin; if she eats lunch around one or two [pm], she gets it after she eats and then for dinner if she eats at nine, ten or eleven [pm] they [ULPs] give it to her after she eats; it is her choice." On November 20, 2024, at 12:43 p.m., CNS-C stated R1 gets insulin three times a day, if R1 eats at midnight R1 will get insulin at midnight as	{01760}			

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{01760}	Continued From page 41 long as it is eight hours apart. CNS-C stated they asked the ULPs who administered insulin on November 3, 2024, at 12:52 a.m., and 1:38 a.m., and the ULPs said they gave it on time and charted late. The surveyor inquired how the ULPs would know if it was charted late, and how would they know what time the insulin was given to determine the next administration time. CNS-C stated the ULPs get a report from the previous ULP, and the ULPs did not always write a progress note. The surveyor stated to CNS-C that ULP-E and ULP-F worked NOC shift together on November 3, 2024. CNS-C stated, "No they did not." The surveyor informed the CNS that they interviewed the ULPs and learned both ULPs were on duty the night of November 3, 2024. CNS-C then stated, "so they [referring to ULPs] gave the same medication? No, they charted late, one of them charted late." CNS-C stated they did not see any problem with charting late. The licensee's Prescriber's Orders policy dated May 2, 2020, read, "1. Written orders from an authorized prescriber will be obtained for all medications and treatments with which the home health [the licensee's name] Assisted Living assists clients, including over the counter medications. 2. Verbal orders may be accepted by a nurse who records and signs the order and then forwards it to the prescriber for signature no later than seven days after receipt of the verbal order. 3. Telephone, facsimile, or computer-generated orders will be kept confidential. An order received by facsimile must have been signed by the prescriber and a durable copy placed in the clinical record by home care staff. 4. All orders must be signed and dated by the prescriber. If the prescriber omitted a date, the [licensee's name] Assisted Living will date the	{01760}			

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{01760}	Continued From page 42 order when received from the prescriber. 5. Medication orders will include the name of the medication, dosage, and directions for use. 6. The Registered Nurse is responsible for implementing medication and treatment orders or for delegating the orders to the appropriate paraprofessional. 7. Medication and treatment orders will be renewed at least every year or when changes occur." No further information was provided.	{01760}			
{01820} SS=D	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 interview and record review, the licensee failed to maintain current medication orders for one of three residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include:	{01820}			

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{01820}	Continued From page 43 R1 was admitted to the facility on October 31, 2023. R1's diagnoses included, schizoaffective disorder, cannabis use disorder, intellectual disability post-traumatic stress disorder schizophrenia, diabetes mellitus, hypertension, hyperlipidemia, history of malnutrition, and personality disorder. R1's Master Care Plan dated November 20, 2024, indicated the following: - R1 needed full medication management and setup; RN will be responsible for medication management, medication setup/ reconciliation with providers and pharmacy as ordered by the physician; - RN will review/clarify any medication instructions from the physician that are not clear; and - R1 needs frequent dosage changes or review of lab tests-blood glucose. R1's record included unsigned After Visit Summary (AVS) dated October 9, 2024, from a Diabetic and Endocrinology Clinic. On November 19, 2024, at 12:11 p.m., clinical nurse supervisor (CNS)-C stated they did not have signed physician orders for R1, "it was misplaced." On November 19, 2024, at 12:30 p.m., surveyor observed, CNS-C called pharmacy #2, put them on a speaker phone, and requested a copy of all of R1's medication orders from pharmacy #2. On November 20, 2024, at approximately 8:30 a.m., housing manager/unlicensed personal (HM/ULP)-B provided the surveyor with a copy of R1's E-script records received from pharmacy #1 and pharmacy #2.	{01820}			

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{01820}	Continued From page 44 On August 15, 2024, at 2:40 p.m., during the initial survey, the former CNS stated they used two different pharmacies for R1's medication supply and stated they get NovoLog from [pharmacy #1] and Lantus and all oral meds from [pharmacy #2]. The licensee's Medication Administration Policy dated May 5, 2020, indicated the licensed nurse was responsible for assessing medications to assure that all medications are current and ordered by the prescriber and to identify any expired or outdated medications are disposed of according to the license's policy. No further information was provided.	{01820}			
{01890} SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by:	{01890}			
{01910} SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a	{01910}	Not reviewed during this survey.		

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{01910}	Continued From page 45 resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by:	{01910}	Not reviewed during this survey.		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	01960			

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01960	Continued From page 46 review, the licensee failed to follow up on blood glucose results and to document any follow up procedures that were provided to meet one of one resident's (R1) needs. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted to the facility on October 31, 2023. R1's diagnoses included schizoaffective disorder, cannabis use disorder, intellectual disability post-traumatic stress disorder schizophrenia, diabetes mellitus, hypertension, hyperlipidemia, history of malnutrition, and personality disorder. R1's service plan dated July 29, 2024, included the following services: insulin injections by the home health aide/resident assistant (HHA/RA) three times per day, medication administration by the HHA/RA three time per day, record-blood glucose (BG) by the HHA/RA three time per day, and supervision of the blood glucose record by the registered nurse (RN) one day a week. R1's Master Care Plan dated November 20, 2024, indicated the following: - "[R1] has been diagnosed with Type 1 diabetes and is supposed to take insulin with any food. [R1] does not always do so and has a history of poor glucose control Stating [sic] [R1's]	01960			

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01960	Continued From page 47 readings used to be regularly in the 300's but recently have been in the 100's. [R1] checks [their] blood sugar at least twice a day and is very resistive to staff with reminders and assistance with BS [blood sugar] checks. Staff will continue to provide reminders and assistance to take [their] insulin as per MD [medical doctor] orders and to eat healthy. Staff will report any low or high blood sugar readings to RN immediately and call 911 with any emergencies." - R1 was at risk for self-neglect and R1's mental health impacted R1's ability to take their medication as prescribed. R1 became upset and argumentative with staff when discussing the need to follow providers orders; staff will remain calm; provide education to R1 and notify the nurse with any concerns; - RN will review/clarify any medication instructions from the physician that are not clear; and - R1 needs frequent dosage changes or review of lab tests-blood glucose. R1's record included an After Visit Summary (AVS) dated October 9, 2024, from a Diabetic and Endocrinology Clinic which indicated: - Insulin aspart (fast-acting insulin) (NovoLog) 100units/mL FlexPen inject 6 units (u) subcutaneously three times daily after meal and 4 units with small meals/snack. Do not take if not eating. TDD (total daily dose)35 units daily. - check blood glucose four times daily; - contact clinic if your blood glucose is above 200 for 3 consecutive days or if it is under 70 two times in one week; and - treat low blood glucose (less than 70) with ½ cup juice or regular soda or 4 glucose tablets. Recheck blood glucose in 15 minutes. On November 19, 2024, at 12:04 p.m., clinical	01960			

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01960	Continued From page 48 nurse supervisor (CNS)-C stated they did blood glucose checks for R1 and staff recorded it in the computer. CNS-C stated they looked at the service recap summary for R1, however, CNS-C was not able to find values for R1's blood glucose results. The record only indicated initials of ULPs who conducted the blood sugar checks. The surveyor asked CNS-C to sign into Rtask and the surveyor was able find the blood sugar results under the report section, subsection "blood glucose". The surveyor observed high blood sugar results recorded ranging from 300 to 548 on multiple occasions for the period of November 1, through November 19, 2024. On November 20, at 9:45 a.m., the surveyor observed a screen shot taken from Rtask (electronic medical record system) for R1's Record blood glucose order indicated, "Wearing gloves and following agency procedure, check blood glucose before eating. Give Insulin after eating then record. **IF BLOOD SUGAR IS LESS THAN 70 GIVE (4) FOUR GLUCOSE TABLETS THEN NOTIFY RN*** Notify RN if: Blood sugar is below 70 or above 300. Notify RN if pt is shaking, sweating, headache, fatigue, or with any concerns." On November 20, 2024, at 10:27 a.m., the surveyor referred to blood glucose test results printed from Rtask and inquired if CNS-C was aware of the high blood sugar results ranging from 300 to 548 on multiple occasions for the period of November 1 through November 19, 2024. CNS-C stated they were not notified about any of the high blood sugars noted on the report. On November 20, 2024, at approximately 11:15 a.m., ULP-E stated they call the CNS-C for blood sugars over 300, and they also stated they	01960			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35884	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 11/22/2024
NAME OF PROVIDER OR SUPPLIER COMFORT CARE ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 414 EAST 26TH STREET MINNEAPOLIS, MN 55404			
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01960	Continued From page 49 document the result in Rtask. On November 20, 2024, at approximately 12:30 p.m., CNS-C stated they reviewed the medication administration record (MAR) once a week and as needed with changes. CNS-C stated the blood sugar results did not show under the MAR or service recap summary, and they were not able to review blood sugars. CNS-C stated their training of Rtask was "not that much", they were still in training, and they were learning. CNS-C stated they were trained on how use Rtask by the licensed assisted living director (LALD)-D; the training included how to enter medication into rtask, how to confirm orders entered by the pharmacy, and how to write a progress note. CNS-C also stated they received training on how to use Rtask by the Rtask software company. On November 20, 2024, at 12:40 p.m., CNS-C stated they got hired at the licensee in February 2024, they worked for two weeks and had to leave for an emergency. CNS-C stated they got rehired couple months ago; they did not know the exact date. The Employee List provided to the surveyor on November 20, 2024, at 9:20 a.m., via email correspondence indicated CNS-C was hired on February 13, 2024. On November 22, 2024, at 9:58 a.m., ULP-A stated they were trained to call the nurse when blood sugars were over three hundred or below seventy. ULP-A stated they called HM/ULP-B when blood sugars where high since they did not have the nurse's phone number. On November 22, 2024, at 10:04 a.m., HM/ULP-B stated R1's blood sugar was always high, R1 makes poor choices when eating and the doctors were aware. HM/ULP-B stated they	01960			

Minnesota Department of Health

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01960	Continued From page 50 only notified the nurse when R1's blood sugars were over 400. The licensee's Treatment and Therapy Management policy dated May 2, 2020, indicated, " 3. If the RN or licensed professional delegates** treatments or therapies, the professional will monitor and evaluate its effectiveness on a regular basis as specified in the service plan." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960			
02320 SS=F	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure residents received appropriate care and services by staff who were properly trained and competent when clinical nurse supervisor (CNS)-C was not properly trained on how to review critical blood sugar values for one of one resident R1. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	02320			

Minnesota Department of Health

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02320	Continued From page 51 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 Employee List provided to the surveyor on November 20, 2024, at 9:20 a.m., via email correspondence indicated CNS-C was hired on February 13, 2024. R1's service plan dated July 29, 2024, included the following services: insulin injections by the home health aide/resident assistant (HHA/RA) three times per day, medication administration by the HHA/RA three time per day, record-blood glucose (BG) by the HHA/RA three time per day, and supervision of the blood glucose record by the registered nurse (RN) one day a week. R1's Master Care Plan dated November 20, 2024, indicated, - R1 needed full medication management and setup; RN will be responsible for medication management, medication setup/ reconciliation with providers and pharmacy as ordered by the physician; - RN will review/clarify any medication instructions from the physician that are not clear; and - R1 needs frequent dosage changes or review of lab tests-blood glucose. On November 19, 2024, at 12:04 p.m., CNS-C stated they did blood glucose checks for R1 and staff recorded it in the computer. CNS-C looked at the service recap summary for R1 and was not able to find the values for blood glucose test	02320			

Minnesota Department of Health

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02320	Continued From page 52 results. R1's medication administration record (MAR) only indicated the initials of unlicensed personnel (ULP) who conducted the blood sugars. The surveyor asked the CNS to sign into Rtask and the surveyor was able find the blood sugar results in Rtask under the report section "blood glucose". The surveyor observed high blood sugar results ranging from 300 to 548 on multiple occasions for the period of November 1 through November 19, 2024. On November 20, at 9:45 a.m., the surveyor observed a screen shot taken from Rtask (electronic medical record system) for R1's Record blood glucose order indicated, "Wearing gloves and following agency procedure, check blood glucose before eating. Give Insulin after eating then record. **IF BLOOD SUGAR IS LESS THAN 70 GIVE (4) FOUR GLUCOSE TABLETS THEN NOTIFY RN*** Notify RN if: Blood sugar is below 70 or above 300. Notify RN if pt is shaking, sweating, headache, fatigue, or with any concerns." On November 20, 2024, at approximately 10:05 a.m., the surveyor inquired CNS-C to explain the AM, PM and NOC insulin administration time frames. CNS-C stated AM is 7 a.m., to 8 a.m., PM is 11 p.m., to 2 p.m., and NOC is 6 p.m., to 8p.m. CNS-C stated, "Their computer system is a little wired. I do not know their system, you are asking the wrong person." On November 20, 2024, at 10:27 a.m., the surveyor referred to blood glucose test results printed from Rtask and inquired if CNS-C was aware of the high blood sugar results ranging from 300 to 548 on multiple occasions for the period of November 1 through November 19, 2024. CNS-C stated they were not notified about	02320			

Minnesota Department of Health

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02320	Continued From page 53 any of the high blood sugars noted on the report. On November 20, 2024, at approximately 12:30 p.m., CNS-C stated they reviewed the MAR once a week and as needed with changes. CNS-C stated the blood sugar results did not show under MAR or service recap summary, and they were not able to review blood sugars. CNS-C stated there training of rtask was not that much and they stated they are still in training, and they are learning. CNS-C stated they were trained on how use Rtask by the licensed assisted living director (LALD)-D; the training included how to enter medication into rtask, how to confirm orders entered by the pharmacy, and how to write a progress note. CNS-C also stated they received training on how to use Rtask by the Rtask software company. On November 21, 2024, at 1:42 p.m., the surveyor attempted to reach LALD-D and was unable to reach the LALD or leave a voice message as the voice message inbox was full and could not accept messages. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	02320			
{03090} SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this	{03090}			

Minnesota Department of Health

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{03090}	Continued From page 54 subdivision. This MN Requirement is not met as evidenced by:	{03090}	Not reviewed during this survey.		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

October 3, 2024

Licensee

Comfort Care Assisted Living

414 East 26th Street

Minneapolis, MN 55404

RE: Project Number(s) SL35884015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 16, 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.

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.

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

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

1750 - 144g.71 Subd. 7 - Delegation Of Medication Administration - \$3,000.00

1760 - 144g.71 Subd. 8 - Documentation Of Administration Of Medication - \$3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$9,000.00.** 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>

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

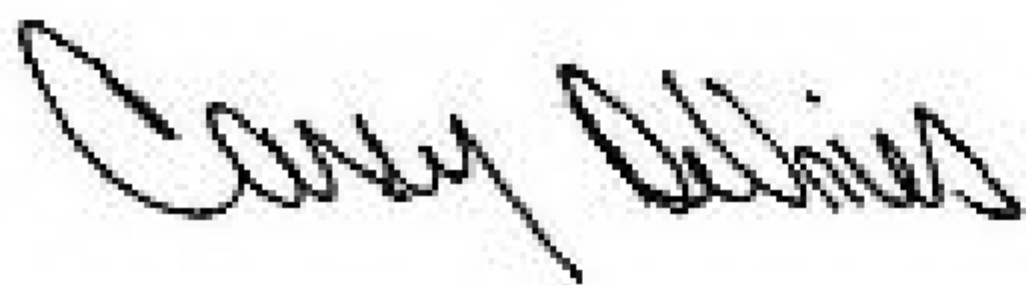
the website listed above.

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 black ink, appearing to read "Casey DeVries". The signature is written in a cursive, flowing style.

Casey DeVries, Supervisor

State Evaluation Team

Email: casey.devries@state.mn.us

Telephone: 651-201-5917 Fax: 1-866-890-9290

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35884	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2024
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0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL35884015-0 On August 12, 2024, through August 16, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were three residents, all of whom received services under the Assisted Living license. The immediacy of order with tag identification 1290 was removed on August 13, 2024. Noncompliance remained, and the scope and level remain unchanged at G. The immediacy of order with tag identification 1760 was not removed prior to survey exit on August 16, 2024.		0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that:		0 470		

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 470	Continued From page 1 (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a written staffing plan that included an evaluation completed by the clinical nurse supervisor (CNS) (as indicated in Minnesota Administrative Rule 4659.0180) at least twice a year to determine staffing levels to meet the needs of all residents and failed to ensure the required staffing schedule was posted for residents, staff, and visitors to review as required. This had the potential to affect all residents, staff,	0 470			

Minnesota Department of Health

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0 470	Continued From page 2 and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living facility license. The facility was licensed for a bed capacity of six residents and had a current census of four residents. POSTING On August 12, 2024, at 9:50 a.m., the surveyor observed an employee schedule dated December 2023, posted on the wall in the living room by the main entrance. The licensee's posted employee schedule was not up to date. On August 12, 2024, at 10:24 a.m., housing manger/unlicensed personal (HM/ULP)-B stated they did not have the staffing schedule printed and posted. They stated everyone knows their shift and everybody comes to work for their shift. On August 12, 2024, at approximately 10:30 a.m., the surveyor inquired of clinical nurse supervisor (CNS)-C about posting a staffing schedule. CNS-C stated, "I do not do the schedule I am a nurse." CNS-C then asked HM/ULP-B if they had a staffing schedule posted. HM/ULP-B stated they did not have a staffing schedule, "we just come on our shifts, they tell us our shifts and we	0 470			

Minnesota Department of Health

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0 470	Continued From page 3 come in for our shifts." On August 12, 2024, at approximately 10:35 a.m., CNS-C took the staffing schedule dated December 2023 off the wall and stated HM/ULP-B was printing the staffing schedule. On August 12, 2024, at 10:37 a.m., HM/ULP stated "the people who cut the check for us are sending it [referring to the schedule] to me." The licensee's undated 4.06 Staffing & Scheduling policy indicated the daily work schedule must be posted, after redacting direct-care staff members' resident assignments, at the beginning of each work shift in a central location in each building of a facility or campus, accessible to staff, residents, volunteers, and the public. The facility shall not disclose any information that is protected by law from public disclosure. STAFFING PLAN On August 12, 2024, at 11:20 a.m., CNS-C provided the surveyor with a staffing plan which was last reviewed on October 11, 2022. On August 12, 2024, at 11:21 a.m., CNS-C stated they did not do the staffing plan, the director develops the staffing plan. CNS-C stated they were aware of the requirement for developing, reviewing staffing plan. They also stated they were aware of the requirement for posting daily staffing schedules. The licensee's undated 4.06 Staffing & Scheduling policy indicated the clinical nurse supervisor, would develop, write, and implement a staffing plan that would provide sufficient staff to meet the residents needs 24-hours a day,	0 470			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35884	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2024
NAME OF PROVIDER OR SUPPLIER COMFORT CARE ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 414 EAST 26TH STREET MINNEAPOLIS, MN 55404		
(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
0 470	Continued From page 4 seven-days a week. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470			
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared 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 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 the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated August 13, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24	0 480			

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0 480	Continued From page 5 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance.	0 480			
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, 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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records included all required content for two of three employees (clinical nurse supervisor (CNS)-C, housing manager/unlicensed personnel	0 650			

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0 650	Continued From page 6 (HM/ULP)-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-C was hired on June 17, 2020, to provide supervision and oversight to unlicensed personnel and to provide direct services to residents. HM/ULP-B was hired on October 24, 2020, to provide direct care services to resident and to perform housing manager duty. HM/ULP-B and CNS-C's employee records lacked documentation of annual performance reviews identifying areas of improvement needed and training needs. On August 12, 2024, at 2:15 p.m., CNS-C stated agent (A)-G did the annual performance reviews. On August 13, 2024, at 11:38 a.m., licensed assisted living director (LALD)-D stated they were aware of the requirement to do annual performance reviews for all employees. LALD-D stated they did do the performance reviews for all employees except CNS-C. The licensee's performance evaluation policy dated May 2, 2020, indicated a formal performance review evaluation will be conducted	0 650			

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0 650	Continued From page 7 for all staff providing cares at least annually. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650			
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), to include an updated facility TB risk assessment. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a	0 660			

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0 660	Continued From page 8 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The facility TB risk assessment was completed June 1, 2020, and indicated the facility was at a low risk for TB transmission and the licensee would conduct or update the TB risk assessment annually. The licensee lacked an updated TB risk assessment. On August 13, 2024, at 11:54 a.m., licensed assisted living director (LALD)-D via telephone, stated the facility TB risk assessment was updated and was kept in the survey binder. LALD-D stated they did not know why the updated document was not found in the survey binder. LALD-D stated they will send the updated facility TB risk assessment to the evaluator via email. The evaluator never received an email from LALD-D. The Facility Tuberculosis (TB) Risk Assessment Instructions and Worksheet for Health Care Settings Licensed by MDH dated June 2024, indicated facilities should perform a facility risk assessment on an annual basis. The licensee's Facility Tuberculosis (TB) Risk Assessment dated June 1, 2020, indicated the facility will complete the Community TB Risk Assessments annually.	0 660			

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0 660	Continued From page 9 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660			
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 review the missing resident policy quarterly in accordance with Minnesota	0 680			

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0 680	Continued From page 10 Rule Chapter 4659.0110, subpart 4. This 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, 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 Missing Resident Policy dated May 2, 2020, lacked documentation of quarterly review. On August 13, 2024, at 11:51 a.m., licensed assisted living director (LALD)-D via telephone, stated their understanding of the required timeline for reviewing the missing resident policy was to do the review annually, and they stated that they reviewed the missing resident policy semi-annually. The licensee was unable to provide evidence that the missing resident policy was reviewed semi-annually. The licensee's Missing Resident Policy dated May 2, 2020, read, " Policy Statement: Residents at [licensee] are not restricted from leaving their home in the facility. However, [licensee] requests that residents notify a staff member when leaving the building. [Licensee] will immediately investigate any missing resident using an organized approach in order to ensure that if a resident is found to be missing, the appropriate authorities are notified.	0 680			

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0 680	Continued From page 11 [Licensee] does not have a locked "memory care" unit and does not normally accept residents who wander or have a history of elopement. Residents may, however, have a diagnosis of Alzheimer's or dementia." Minnesota Rules Chapter 4659.0110, Subpart 4. dated August 11, 2021, indicated the assisted living director 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 (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 the individual dwelling unit or sleeping unit to	0 780			

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0 780	Continued From page 12 operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the required smoke alarm inside the lower-level resident bedroom 5 and failed to provide smoke alarms that are interconnected so that the activation of one alarm causes all alarms in the home to operate for proper notification. This has 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 August 13, 2024, from, 10:10 a.m. to 11:10 a.m., survey staff toured the home with the housing manager/unlicensed personnel (HM/ULP)-C. During the tour, survey staff observed the following upon testing the home's smoke alarms: -No smoke alarm was observed inside bedroom 5. The HM/ULP-C explained they are using this room as an office. Survey staff explained to the HM/ULP-C that the posted evacuation diagram	0 780			

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0 780	Continued From page 13 shows the room is a bedroom and a smoke alarm must be provided and be interconnected with the home's smoke alarm system. -The smoke alarm in the hallway of the lower-level floor was not interconnected with the home's smoke alarm system as required. The deficient finding was evident when the lower-level hallway smoke alarm was tested, it sounded local. The above deficient findings were visually and verbally verified by the HM/ULP-C at the time of discovery accompanying the home tour. On August 13, 2024, at approximately noon., survey staff explained the above deficient findings to the HM/ULP-C during the exit interview. The HM/ULP-C understood and acknowledged the findings and had no further questions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780			
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by:	0 800			

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0 800	Continued From page 14 Based on observation and interview, the licensee failed to maintain the physical environment of the facility in a continuous state of good repair and operation. This has the potential to directly affect the health, safety, and well-being of the residents, visitors, and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: On August 13, 2024, from, 10:10 a.m. to 11:10 a.m., survey staff toured the home with the housing manager/unlicensed personnel (HM/ULP)-C. During the home tour, survey staff observed the following: -The licensee lacked maintenance on the removal of plants/shrubs to keep the bedroom egress windows and pathway free of obstructions for use during an emergency. The window well in the lower-level resident room 2 were obstructed with plants and the outside exit pathway from the lower-level resident room 5 egress window had obstructions from plants and fencing. The HM/ULP-C verified the findings at the time of discovery. -The lower-level resident room 5 door had hasp hardware on the doors located outside of the room that can be locked in the means of egress if a padlock was used which could restrict exiting from inside the room. Survey staff explained that	0 800			

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0 800	Continued From page 15 any accidental locking of the door using a padlock could restrict egress from the inside during an emergency. The HM/ULP-C verified the finding at the time of discovery and stated that the room is used as an office and not for residents. The HM-ULP-C further explained they would replace the existing door hardware with standard privacy door hardware. -The door lock hardware on the main level bathroom was comprised and not properly functioning to provide for resident privacy. -The door of resident room 1 failed to latch when survey staff attempted to close the door multiple times. Survey staff explained to the HM/ULP-C that the door must latch positively for locking when closed for resident privacy and fire/smoke protection during a fire emergency. The HM/ULP-C stated that they would fix it. -The shower compartment base inside lower-level resident room 2 lacked cleaning. Survey staff observed dark stains on the base perimeter. The above deficient findings were visually and/or verbally verified by the HM/ULP-C at the time of discovery. On August 13, 2024, at approximately noon, survey staff explained the above deficient findings to the HM/ULP-C during the exit interview. The HM/ULP-C understood and acknowledged the findings and had no further questions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800			

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0 810	Continued From page 16	0 810			
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, document and record	0 810			

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0 810	Continued From page 17 review, and interview, the licensee failed to provide all required contents on the fire safety and evacuation plan, the minimum number of fire evacuation drills for calendar years, 2022 and 2023, and the required minimum training of staff and residents on the fire safety and evacuation plan for calendar years, 2022 and 2023. This has the potential to directly affect the safety of visitors, staff, and all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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: On August 13, 2024, from, 10:10 a.m. to 11:10 a.m., survey staff toured the home with the housing manager/unlicensed personnel (HM/ULP)-C. During the tour, survey staff observed the following: -The posted fire evacuation layout diagrams did not include room numbers for each resident bedroom. Evacuation plans must include the location and resident sleeping room numbers. The HM/ULP-C verified that the layout floor diagrams lacked the room numbers. -The posted fire evacuation layout diagram on the upper level was not accurate as the diagram showed a kitchen and family room when there were none. The HM/ULP-C visually and verbally verified that the posed evacuation layout diagram for the upper-level floor was not accurate.	0 810			

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0 810	Continued From page 18 On August 13, 2024, at approximately 11:15 a.m., document and record review and interview with the HM/ULP-C on the home's fire safety and evacuation plan, titled Fire Emergency, dated August 1, 2021, indicated the following: -Document review indicated the licensee's fire safety and evacuation plan failed to include site-specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and conditions, and resident movements during a fire or similar emergency. The fire safety plan was from a third-party provider and included sprinklers, and magnetic door holders, and had not been updated to the home's site-specific conditions. -Document review indicated the licensee's fire safety and evacuation plan did not include and identify in the plan the specific fire protection procedures for residents who are capable of self-evacuation on the proper actions to be taken in case of a fire or similar emergency. -Record review of available documentation indicated that the licensee did not provide employee training on the fire safety and evacuation plan twice per year after the initial hire training for calendar years 2022 and 2023. Survey staff received training records for review for 2024 but no documentation or records were available or provided for the previous two years. -Record review of the available documentation indicated the licensee failed to provide required evacuation training to residents who are capable of self-evacuation on the proper actions to be taken in the case of a fire or similar emergency including movement, evacuation, and relocation at least once per year. Record review indicated proper training was provided for 2024, but did not receive documentation or records to show that	0 810			

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0 810	Continued From page 19 the training was offered to residents for the previous two years. -Record review indicated the licensee failed to provide the minimum required employee fire evacuation drills twice per year, per shift with at least one evacuation drill every other month for the previous calendar years, 2022 and 2023. Record review indicated evacuation drills were properly conducted to date for 2024, but no records or logs were provided or available for review for previous years. The above deficient findings were verified by the HM/ULP-C during the interview. On August 13, 2024, at approximately noon, during the exit interview, survey staff explained the above deficient findings to the HM/ULP-C. The HM/ULP-C understood and acknowledged the findings. No further information was provided. 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	0 950			

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0 950	Continued From page 20 "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 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 include the required statutory language giving residents the right to identify a designated representative in writing in the contract and failed to provide the required verbatim notice on its own separate page for two of two residents (R1, 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 the potential to affect a large portion or all the residents). The findings include:	0 950			

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0 950	Continued From page 21 R1 R1's Assisted Living Contract was signed on October 31, 2023. R3 R3's Assisted Living Contract was signed on May 24, 2024. The licensee's Assisted Living Contract form utilized for the above listed residents lacked the required verbatim "right to designate a representative for certain purposes" notice on a document separate from the contract. On August 15, and 16, 2024, the surveyor made multiple unsuccessful phone call attempts to reach licensed assisted living director (LALD)-D and the owner. The surveyor was unable to reach the individuals for interview. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 950			
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the	01060			

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01060	Continued From page 22 location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with required content for an emergency relocation for two of two residents (R2, R3). This practice resulted in a level two violation (a	01060			

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01060	Continued From page 23 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: R2 R2's diagnoses included schizoaffective disorder, bipolar disorder, border line personality disorder behavioral disturbances, post-traumatic stress disorder, and noncompliance with medication. R2's service plan, signed dated November 17, 2022, indicated R2 received assistance with dressing, grooming, housekeeping and linen change, laundry, manage symptom and behavior, appointment reminder, and medication administration. On August 14, 2024, at approximately 12:15 p.m., clinical nurse supervisor (CNS-C) stated R2 was hospitalized from December 29, 2023, to January 23, 2024. R3 R3's diagnoses included schizoaffective disorder, bipolar disorder, anxiety, major depressive disorder, delusion, and chronic right shoulder pain. R3's unsigned service plan, dated August 15, 2024, indicated R3 received assistance with dressing, grooming, housekeeping and linen change, laundry, manage symptom and behavior, meal reminder, and record vital signs.	01060			

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01060	Continued From page 24 R3's record indicated R3 was hospitalized on July 30, 2024, and had not returned to the facility at the time of this survey. R2 and R3's records lacked evidence a written notice was provided to the residents that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the Office of Ombudsman for Long-Term Care; - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. On August 14, 2024, at 12:30 p.m., clinical nurse supervisor (CNS)-C stated R2 went to the hospital for treatment and got admitted. R2 refused any type of interaction or forms. CNS-C stated they tried to talk to R2's family and R2's family was not ready to have a discussion. CNS-C was not aware of the requirement to notify the ombudsman for hospital admissions. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060			

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01290	Continued From page 25	01290			
01290 SS=G	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 section 13.02, subdivision 12. (c) Termination of an employee 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: Based on interview and record review, the licensee failed to ensure a background study (BGS) was submitted and received in affiliation with the assisted living license for one of ten employees (housing manger/unlicensed personnel (HM/ULP)-B). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at 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:	01290			

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01290	Continued From page 26 HM/ULP-B was hired on October 24, 2020, to provide direct cares and services to residents. HM/ULP-B's employee record included a background study clearance letter from the Department of Human Services dated August 13, 2020, under a closed comprehensive license, health facility identification (HFID) 34997. The NETstudy 2.0 roster (a web-based system used for submitting background study requests to the Department of Human Services) for HFID 34997 indicated HM/ULP-B's BGS was expired on December 31, 2022. The licensee's NETstudy 2.0 roster indicated HM/ULP-B's BGS was in process for determination with affiliation date of August 13, 2024 (during the survey). The licensee lacked evidence HM/ULP-B was affiliated to the licensee's HFID 35884. The licensee's staffing schedule for the month of August 2024 indicated HM/ULP-B was scheduled to work AM shift (7:00 a.m. to 3:00 p.m.) and PM shift (3:00 p.m. to 10:00 p.m.) every day from August 1, 2024, to August 31, 2024. On August 13, 2024, at 11:12 a.m., via telephone, licensed assisted living director (LALD)-D stated they were not aware ULP-B did not have a cleared BGS. LALD-D stated HM/ULP-B was hired before they started working for the licensee. LALD-D stated they did an audit on employee records and stated they did not pay attention to the HFID number on the clearance letter on file for HM/ULP-B. On August 13, 2024, at 11:37 a.m. clinical nurse supervisor (CNS)-C stated HM/ULP-B worked with residents without supervision as the BGS	01290			

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01290	Continued From page 27 affiliated to the closed comprehensive license HFID 34997 did not indicate supervision was required. On August 13, 2024, the Minnesota Department of Human Services website indicated the following: Emergency studies completed during the COVID-19 pandemic were no longer valid. Individuals who only had an emergency study must have a fully compliant, fingerprint-based background study. Roster maintenance - Individuals with a completed emergency study will remain on the entity's roster unless the entity removes the individual. Entities should remove individuals with emergency studies that are no longer affiliated; - If the individual should no longer be affiliated and has a new fully compliant background study, the entity should wait until the individual is separated and then remove both the emergency study and fully compliant study from their roster at the same time; - All entities are responsible for maintaining their rosters regularly and removing study subjects from their roster when they are no longer affiliated; and - Entities are responsible for identifying who needs to submit a new background study. For help identifying which study subjects still have an emergency study and need a fully compliant study, entities should refer to the instructional guide, "Identifying Emergency Studies" in the help section of NETStudy 2.0. The licensee's 2.34 Background Checks policy dated January 1, 2020, read, "POLICY: [Name of Assisted living (AL)] will conduct a Minnesota Department of Human Services Background	01290			

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01290	Continued From page 28 Study on all employees of [Name of AL] who will have independent, unsupervised contact with tenants or clients of [Name of AL]. No employee may have independent direct contact with any tenants or clients until acceptable result of the background study have been received. [Name of AL] will not employ individuals whose results of the background study indicate disqualification for the position." No further information was provided. TIME PERIOD FOR CORRECTION: Immediate The immediacy of order with tag identification 1290 was removed on August 13, 2024. Noncompliance remained, and the scope and level remain unchanged at G.	01290			
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such	01500			

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01500	Continued From page 29 as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated 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:	01500			

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01500	Continued From page 30 Based on interview and record review, the licensee failed to ensure an employee received at least eight hours of annual training for each 12 months of employment for three of three employees (clinical nurse supervisor (CNS)-C, housing manager/unlicensed personnel (HM/ULP)-B, 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 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 the residents). The findings include: CNS-C was hired on June 17, 2020, to provide supervision and oversight to unlicensed personnel and to provide direct services to residents. HM/ULP-B was hired on October 24, 2020, to provide direct care services to residents and to perform housing manager duty. ULP-E was hired on October 27, 2022, to provide direct care services to resident. CNS-C, HM/ULP-B, and ULP-E's employee records lacked eight hours of annual training completed within the last 12 months to include: - reporting maltreatment of vulnerable adults; - assisted living bill rights; - infection control techniques; - effective approaches to use to problems solve when working with a resident's challenging behaviors, and how to communicate with	01500			

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01500	Continued From page 31 residents who have dementia, Alzheimer's disease, or related disorders; - review of provider policies and procedures; and - principles of person-centered planning/service delivery. On August 12, 2024, at 2:06 p.m., CNS-C stated agent (A)-G assigned training modules to employees. On August 14, 2024, at 11:40 a.m., licensed assisted living director (LALD)-D stated they did not know why the required trainings were not completed. LALD-D stated CNS-C was supposed to assign training modules to each employee through Educare (a software used by the licensee for educating staff). On August 14, 2024, at 11:40 a.m., CNS-C stated they know how to assign trainings, they used to assign trainings, but not anymore. CNS-C stated A-G assigned training modules to employees. The licensee's Staff Orientation and Education policy dated May 2, 2020, read, "10. All staff providing direct home care will complete at least eight (8) hours of education for every twelve (12) months of employment. 11. Education topics will include, but not be limited to, the following a. Reporting of maltreatment of adults or minors b. Review of Home Care Bill of Rights c. Review of the organization's policies and procedures related to implementation of home care services d. Infection control techniques used in the home i. Implementation of infection control standards based on current recommendations	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 32 per the CDC**** ii. Hand washing iii. Need for/use of personal protective equipment (PPE) iv. Appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes and razor blades v. Disinfection of reusable equipment vi. Disinfection of environmental surfaces vii. Reporting of communicable diseases" No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500			
01530 SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor	01530			

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01530	Continued From page 33 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 three of four employees (unlicensed personnel (ULP)-A, housing manager (HM)/ULP-B, ULP-E) received at least eight hours of initial dementia care training within 160 working hours of their employment start date and two hours of dementia training annually. 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 the potential to affect a large portion or all of the residents). The findings include: ULP-A was hired on May 15, 2024, to provide direct care services to resident. HM/ULP-B was hired on October 24, 2020, to provide direct care services to resident and to perform a housing manager duty. ULP-E was hired on October 27, 2022, to provide direct care services to resident. ULP-A's employee record included an Educare	01530			

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01530	Continued From page 34 (online training platform) training document which indicated ULP-B had 5.75 hours of dementia training completed on May 11, 2024, which was 2.25 hours short of the required eight hours of dementia training. HM/ULP-B's employee record included initial dementia training last completed April 11, 2020. HM/ULP-B's employee record also included [licensee's name] Staff Training Transcript dated January 1, 2020, to August 12, 2024, which indicated zero hours of dementia training was completed. On August 14, 2024, at 2:19 p.m., the surveyor received ULP-E's transcript via email. The transcript included zero hours of dementia training completed. ULP-E's employee record lacked evidence to show any dementia training was completed. On August 14, 2024, at 5:49 p.m., the surveyor received ULP'E's transcript via email which indicated 8.75 hours of dementia training completed on August 14, 2024 (after initiation of the survey). On August 12, 2024, at 2:06 p.m., clinical nurse supervisor (CNS)-C stated agent (A)-G assigned training modules to employees. On August 14, 2024, at 11:40 a.m., licensed assisted living director (LALD)-D stated they did not know why the required trainings were not completed as the clinical nurse supervisor was supposed to assign training module to each employee through Educare. On August 14, 2024, at 11:40 a.m., CNS-C stated they knew how to assign trainings, and they used	01530			

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01530	Continued From page 35 to assign training but not anymore. CNS-C stated A-G assigned training modules to employees. The licensee's Staff Orientation and Education policy dated May 2, 2020, read, "5. [licensee's name] does not provide training related to Alzheimer's Disease". No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530			
01610 SS=E	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to a conduct a nursing	01610			

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01610	Continued From page 36 assessment by a registered nurse (RN) of the physical and cognitive needs for two of three residents (R2, R3) on or before the admission date. 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 diagnosis included schizoaffective disorder, bipolar disorder, border line personality disorder behavioral disturbances, post-traumatic stress disorder, and noncompliance with medication. The licensee's Discharge Resident/Client roster dated August 1, 2020, to August 12, 2024, indicated R2 was admitted to the licensee on November 1, 2022, and discharged on February 28, 2024. The licensee's Current Client Roster: Comprehensive (144A) dated August 12, 2024, indicated R2 was admitted to the licensee on November 10, 2022. R2's record included a Discharge - Transfer Summary completed by clinical nurse supervisor (CNS)-C on March 12, 2024. The discharge transfer summary indicated R2 started receiving care on November 1, 2022, and discharged to	01610			

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01610	Continued From page 37 another licensee on February 28, 2024. On August 16, 2024, at 11:58 a.m., CNS-C via email correspondence, indicated R2's readmission date was May 17, 2024. R2's service plan signed and dated November 17, 2022, indicated R2 received assistance with dressing assistance, grooming assistance, housekeeping and linen change, laundry, manage symptom and behavior, appointment reminder, and medication administration. R2's service plan was completed three days after the required "within 14 days of admission" timeline for the first admission date of November 1, 2022. R2's record included a Clinical Update Assessment completed on July 20, 2024, 64 days after admission date. R2's record lacked an admission assessment which was due on or before May 17, 2024. On August 14, 2024, at 12:15 p.m., CNS-C stated they did not know why an admission assessment was not completed on time. CNS-C stated "I was not the nurse when [R2] came back." R3 The licensee's Current Client Roster: Comprehensive (144A) dated August 1, 2020, to August 12, 2024, indicated R3 was admitted to the licensee on May 25, 2024. R3's diagnosis included schizoaffective disorder, bipolar disorder, anxiety, major depressive disorder, delusion, and chronic right shoulder pain. R3's unsigned Service Plan (Waiver) - Addendum	01610			

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01610	Continued From page 38 to Contract, dated August 15, 2024, indicated R3 received assistance with dressing assistance, grooming assistance, housekeeping and linen change, laundry, manage symptom and behavior, meal reminder, and record vital signs. R3's record included the following: -admission assessment completed on June 5, 2024, which was late by 11 days; and -14-day assessment completed on June 7, 2024. R3's record lacked admission assessment which was due on or before May 25, 2024. On August 14, 2024, at 1:50 p.m., CNS-C stated they did not know why the admission assessment was not completed on time. CNS-C stated they were not there when R3 got admitted. The licensee's Assessment-Comprehensive Services dated May 2, 2020, read " 1. The RN will provide the admission visit and conduct a comprehensive assessment, including the following i. Client Evaluation j. Vulnerability Assessment k. Falls Risk Assessment (if appropriate) l. Mental Status Assessment (if appropriate) m. Home Safety Checklist (if appropriate) n. Medication Profile (if appropriate) o. Home Health Aide Care Plan (if appropriate) p. Emergency Information 2. The initial assessment must be completed within five (5) days after the date that home care services are first provided. 3. If services are provided to a client before the assessment, the RN will complete a temporary plan with the client and orient staff to services as identified in the temporary plan. 4. The RN will provide a reassessment visit to	01610			

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01610	Continued From page 39 update the evaluation of the client and services no more than 14 days after initiation of services. 5. No later than 14 days after the initiation of services, the service plan* is finalized if not already completed. 6. Ongoing client monitoring and reassessment must be conducted as needed based on changes in the needs of the client, but cannot exceed 90 days from the last date of assessment. 7. The monitoring and reassessment may be conducted at the client's residence or through the utilization of telecommunication methods based on practice standards that meet the individual client's needs." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01610			
01620 SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90	01620			

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01620	Continued From page 40 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted a reassessment and monitoring no more than 14 calendar day after the initiation of service for two of three residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number 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 was admitted on October 31, 2023. R1's diagnoses included schizoaffective disorder, cannabis use disorder, intellectual disability post-traumatic stress disorder schizophrenia, diabetes mellitus, hypertension, hyperlipidemia, history of malnutrition, and personality disorder. R1's service plan dated July 29, 2024, included the following services: appointment reminders,	01620			

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01620	Continued From page 41 bathing reminders, declutter room, delegated clinical monitoring dressing assistance, grooming, housekeeping, insulin injection, laundry, manage behaviors, mange symptoms, medication administration, and record blood glucose. R1's record included an admission assessment completed on November 1, 2023, and a 14-day assessment on November 16, 2023, which was late by two days. On August 13, 2024, at 2:31 p.m., clinical nurse supervisor (CNS-C) stated the 14th of November fell on the weekend, that was why the assessment was not done timely. R2 R2's diagnosis included schizoaffective disorder, bipolar disorder, border line personality disorder behavioral disturbances, post-traumatic stress disorder, and noncompliance with medication. The licensee's Discharge Resident/Client roster dated August 1, 2020, to August 12, 2024, indicated R2 was admitted to the licensee on November 1, 2022, and discharged on February 28, 2024. The licensee's Current Client Roster: Comprehensive (144A) dated August 12, 2024, indicated R2 was admitted to the licensee on November 10, 2022. R2's record included a Discharge - Transfer Summary completed by CNS-C on March 12, 2024. The discharge transfer summary indicated R2 started receiving care on November 1, 2022, and discharged to another licensee on February 28, 2024.	01620			

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01620	Continued From page 42 On August 16, 2024, at 11:58 a.m., CNS-C via email correspondence, indicated R2's readmission date was May 17, 2024. R2's service plan signed and dated November 17, 2022, indicated R2 received assistance with dressing assistance, grooming assistance, housekeeping and linen change, laundry, manage symptom and behavior, appointment reminder, and medication administration. R2's service plan was completed three days after the required "within 14 days of admission" timeline for the first admission date of November 1, 2022. R2's record included a Clinical Update Assessment completed on July 20, 2024. R2's record lacked a 14-day assessment which was due on or before May 31, 2024. On August 14, 2024, at 12:15 p.m., CNS-C stated they did not know why the 14-day assessment was not completed on time. CNS-C stated, "I was not the nurse when [R2] came back." The licensee's Assessment-Comprehensive Services dated May 2, 2020, read " 1. The RN will provide the admission visit and conduct a comprehensive assessment, including the following a. Client Evaluation b. Vulnerability Assessment c. Falls Risk Assessment (if appropriate) d. Mental Status Assessment (if appropriate) e. Home Safety Checklist (if appropriate) f. Medication Profile (if appropriate) g. Home Health Aide Care Plan (if appropriate) h. Emergency Information 2. The initial assessment must be completed within five (5) days after the date that home care	01620			

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01620	Continued From page 43 services are first provided. 3. If services are provided to a client before the assessment, the RN will complete a temporary plan with the client and orient staff to services as identified in the temporary plan. 4. The RN will provide a reassessment visit to update the evaluation of the client and services no more than 14 days after initiation of services. 5. No later than 14 days after the initiation of services, the service plan* is finalized if not already completed. 6. Ongoing client monitoring and reassessment must be conducted as needed based on changes in the needs of the client, but cannot exceed 90 days from the last date of assessment. 7. The monitoring and reassessment may be conducted at the client's residence or through the utilization of telecommunication methods based on practice standards that meet the individual client's needs." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620			
01640 SS=E	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident	01640			

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01640	Continued From page 44 about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan was completed within 14 days of admission for two of three residents (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 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 diagnosis included schizoaffective disorder, bipolar disorder, border line personality disorder behavioral disturbances, post-traumatic stress disorder, and noncompliance with medication. The licensee's Discharge Resident/Client roster dated August 1, 2020, to August 12, 2024,	01640			

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01640	Continued From page 45 indicated R2 was admitted to the licensee on November 1, 2022, and discharged on February 28, 2024. The licensee's Current Client Roster: Comprehensive (144A) dated August 12, 2024, indicated R2 was admitted to the licensee on November 10, 2022. R2's record included a Discharge - Transfer Summary completed by clinical nurse supervisor (CNS-C) on March 12, 2024. The discharge transfer summary indicated R2 started receiving care on November 1, 2022, and discharged to another licensee on February 28, 2024. On August 16, 2024, at 11:58 a.m., CNS-C via email correspondence, indicated R2's readmission date was May 17, 2024. R2's service plan, signed and dated November 17, 2022, indicated R2 received assistance with dressing assistance, grooming assistance, housekeeping and linen change, laundry, manage symptom and behavior, appointment reminder, and medication administration. R2's service plan was completed three days after the required "within 14 days of admission" timeline for the first admission date of November 1, 2022. R2's record included an unsigned Master Care Plan completed on July 20, 2024, which was late by 49 days. The Master Care Plan was also not signed and not authenticated. On August 14, 2024, at 12:15 p.m., CNS-C stated they did not know why the service plan was not completed on time. CNS-C stated "I was not the nurse when [R2] came back.	01640			

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01640	Continued From page 46 R3 The licensee's Current Client Roster: Comprehensive (144A) dated August 1, 2020, to August 12, 2024, indicated R3 was admitted to the licensee on May 25, 2024. R3's diagnosis included schizoaffective disorder, bipolar disorder, anxiety, major depressive disorder, delusion, and chronic right shoulder pain. R3's unsigned Service Plan (Waiver) - Addendum to Contract, dated August 15, 2024, indicated R3 received assistance with dressing assistance, grooming assistance, housekeeping and linen change, laundry, manage symptom and behavior, meal reminder, and record vital signs. R3's service plan was completed during survey, and it was completed late by 82 days. The Service Plan (Waiver) - Addendum to Contract was also not signed and not authenticated. On August 14, 2024, at 1:50 p.m., CNS-C stated they did not know why the service plan was not completed on time. CNS-C stated they were not there when R3 was admitted. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640			
01750 SS=G	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the	01750			

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01750	Continued From page 47 proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure specific medication administration instructions for each resident was documented in the resident's record for one of one resident (R1). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted to the facility on October 31, 2023. R1's diagnoses included schizoaffective disorder, cannabis use disorder, intellectual disability post-traumatic stress disorder schizophrenia, diabetes mellitus, hypertension, hyperlipidemia, history of malnutrition, and personality disorder. R1's service plan dated July 29, 2024, included the following services: insulin injections by the	01750			

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01750	Continued From page 48 home health aide/resident assistant (HHA/RA) three times per day, medication administration by the HHA/RA three time per day, record-blood glucose (BG) by the HHA/RA three time per day, and supervision of the blood glucose record by the registered nurse (RN) one day a week. R1's medication administration record (MAR) dated July 2024, indicated the following for NovoLog FlexPen 100 unit (u)/milliliter (mL): -NovoLog FlexPen 100 u/mL Inject six units subcutaneously three times a day before breakfast, lunch, and dinner. The MAR did not include an administration time for the meal doses and had the medication listed with PRN (as needed) medications. R1's MAR indicated the medication was administered on nine of 93 possible meal periods. R1's MAR also contained the following for NovoLog FlexPen 100 u/mL: -Take four units of NovoLog insulin with milk and a snack. The MAR did not include an administration time for the snack dosing and had the medication listed with PRN medications. -The MAR indicated the medication dose was administered on nine occasions during the month of July 2024. R1's MAR dated August 2024, indicated the following for NovoLog FlexPen 100 u/mL: -NovoLog FlexPen 100 u/mL Inject six units subcutaneously three times a day before breakfast, lunch, and dinner. The MAR did not include an administration time for the meal doses and had the medication listed with PRN medications. -R1's MAR indicated the medication was administered on four of 36 possible meal periods. R1's MAR also contained the following for NovoLog FlexPen 100 u/mL:	01750			

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01750	Continued From page 49 -Take four units of NovoLog insulin with milk and a snack. The MAR did not include an administration time for the snack dosing and had the medication listed with PRN medications. -The MAR indicated the medication dose was administered on four occasions from August 1-12, 2024. According to R1's most recent after visit summaries (AVS) dated July 3, 2024, and July 11, 2024, the Novolog with milk was not a current order. On August 13, 2024, at approximately 10:30 a.m., the surveyor observed R1's medication administration performed by unlicensed personnel (ULP)-A. ULP-A administered oral medication to R1. The surveyor did not observe ULP-A perform a BG check or administer injectable medication to R1. On August 13, 2024, at 12:56 p.m., the surveyor requested to see signed physician orders for R1. Clinical nurse supervisor (CNS)-C stated they did not have signed physician orders for R1 and stated the AVS' were the orders. On August 13, 2024, at 1:32 p.m., the surveyor showed R1's insulin order on R1's Medications - Current As of August 13, 2024, to CNS-C, and asked CNS-C to explain their understanding for R1's insulin administration order. CNS-C stated the order to give six units (NovoLog) was scheduled and the order to give four units (NovoLog) was PRN. The surveyor referred the CNS to the list where it indicated PRN for both orders and inquired how the ULPs would know how many units to give and when to give. CNS-C stated it was on the service plan. The surveyor observed CNS-C check the service plan and	01750			

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01750	Continued From page 50 stated the order was not on there. CNS-C then stated the information was in the individual therapy and treatment plan. The surveyor observed CNS-C check the document and stated the order was not there. On August 13, 2024, at 1:36 p.m., housing manger/unlicensed personal (HM/ULP)-B stated they check R1's BG before and after meals. HM/ULP-B stated R1 mostly got four units of insulin, but if R1 ate a big meal they gave R1 six units of insulin. The surveyor inquired what was considered a big meal. HM/ULP-B explained, "let's say [R1] ate hamburger or fries, that is six units, if [R1] ate a slice of bread it is four units, if [R1] does not eat we do not give it to [R1] unless [R1's] blood sugar is over 300 then we give [R1] four units." On August 13, 2024, at 1:50 p.m., ULP-A stated they did not give insulin to R1 that morning because R1 did not eat. On August 13, 2024, at 2:24 p.m., the surveyor inquired about CNS-C's expectation for how the ULPs would know how many units of insulin to give to R1. CNS-C explained for example if R1 eats half of their breakfast it is considered snack; R1 gets four units, and if R1 ate a full breakfast it was considered a meal and R1 gets six units of insulin, and staff do not give insulin if R1 does not eat. On August 13, 2024, at 2:27 p.m., CNS-C stated they did do BG checks when R1 allowed them to do it up to three times a day and PRN. The surveyor asked if they have documentation to show BG checks were done for R1. CNS-C stated it was documented in the MAR. The surveyor stated they did not see the BG results	01750			

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01750	Continued From page 51 documented on the MAR. CNS-C stated it was also in the glucometer machine, it should be documented in the MAR, but "we do not micromanage." On August 13, 2024, at 3:03 p.m., ULP-A stated they check R1's BG level and chart it in the computer. ULP-A stated if the BG was high, they give insulin. The surveyor inquired what was considered high BG. ULP-A stated 170, 180, 200 or above, if R1 ate a lot of food, R1 gets six units and if R1 ate a small amount of food they get four units, but usually, R1 got six units. On August 15, 2024, at 2:40 p.m., CNS-C stated they used two different pharmacies for R1's medication supply and stated they get NovoLog from [pharmacy #1] and Lantus and all oral meds from [pharmacy #2]. On August 15, 2024, at 4:02 p.m., pharmacist from [pharmacy #2] stated they had the following orders for R1: - NovoLog FlexPen 12 units, three times daily before meals and six units before snacks. Maximum daily dose 50 units ordered January 12, 2024. Last refilled April 26, 2024. On August 15, 2024, at 4:13 p.m., pharmacist from [pharmacy #1] stated they had the following orders for R1: - NovoLog FlexPen six units three times a day before meal. Do not take insulin if not eating. Order written on May 8, 2024. Insulin last filled by pharmacy December 2023. R1's most current insulin orders were not accurately reflected on R1's July or August 2024 MARs. The licensee did not ensure the licensed nurse maintained signed provider's orders,	01750			

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01750	Continued From page 52 updated R1's records to reflect changes when made, reconciled medication discrepancies between pharmacy medication labels and AVS', or ensured staff appropriately supervised insulin administration or administered insulin accurately. In addition, based on interviews, CNS-C delegated nursing assessment tasks to ULP's when the ULP's were required to determine insulin doses based on evaluating whether what the resident ate was considered a snack or a meal, instead of specifically following the prescriber's order. The licensee's Prescriber's Orders policy dated May 2, 2020, read, "1. Written orders from an authorized prescriber will be obtained for all medications and treatments with which the home health [the licensee's name] Assisted Living assists clients, including over the counter medications. 2. Verbal orders may be accepted by a nurse who records and signs the order and then forwards it to the prescriber for signature no later than seven days after receipt of the verbal order. 3. Telephone, facsimile, or computer-generated orders will be kept confidential. An order received by facsimile must have been signed by the prescriber and a durable copy placed in the clinical record by home care staff. 4. All orders must be signed and dated by the prescriber. If the prescriber omitted a date, the [licensee's name] Assisted Living will date the order when received from the prescriber. 5. Medication orders will include the name of the medication, dosage, and directions for use. 6. The Registered Nurse is responsible for implementing medication and treatment orders or for delegating the orders to the appropriate paraprofessional. 7. Medication and treatment orders will be	01750			

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01750	Continued From page 53 renewed at least every year or when changes occur." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750			
01760 SS=G	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to administer diabetic medications according to a provider's order, failed to reconcile provider's orders when changes were made, and failed to ensure staff accurately administered insulin and documented the insulin administration in accordance with the resident's medication management plan. This practice resulted in a level three violation (a violation that harmed a resident's health or safety,	01760			

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01760	Continued From page 54 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On August 12, 2024, at 9:45 a.m., upon entry to the facility, the surveyor observed R1 sitting outside by the front door checking their own blood glucose (BG) without supervision. R1 was admitted to the facility on October 31, 2023. R1's diagnoses included schizoaffective disorder, cannabis use disorder, intellectual disability post-traumatic stress disorder schizophrenia, diabetes mellitus, hypertension, hyperlipidemia, history of malnutrition, and personality disorder. R1's service plan dated July 29, 2024, included the following services: insulin injections by the home health aide/resident assistant (HHA/RA) three times per day, medication administration by the HHA/RA three time per day, record-blood glucose by the HHA/RA three time per day, and supervision of the blood glucose record by the registered nurse (RN) one day a week. R1's 90-day assessment dated July 20, 2024, included the following related to R1's diabetic management: -Eating Needs- R1's mental health impacted their ability to remember to eat a diabetic diet and take prescribed insulin per prescriber's orders. Without staff support, encouragement, and assistance, R1 struggled to attend to their needs.	01760			

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01760	Continued From page 55 R1 lacked insight to their needs related to type 1 diabetes, didn't remember to take insulin every time they ate or would request insulin before they ate and then lose their appetite, putting them at risk for hypoglycemia (low BG). -Diabetes Management- R1 needed BG checks and assistance with insulin. R1 was physically able to perform BG checks and administration of insulin but needed staff supervision. R1's mental health impacted their ability to initiate and complete BG checks and take insulin as prescribed without support, encouragement, and assistance to consistently attend to their needs. R1 had a history of emergency room visits related to high and low BG levels. R1 had type 1 diabetes and was supposed to take insulin with any food. R1 did not always do so and has a history of poor glucose control. R1 stated their readings used to be in the 300's but recently had been in the 100's. R1 checked their BG at least twice a day and was very resistive to staff with reminders and assistance for BG checks. Staff would continue to provide reminders and assistance to take insulin as per prescriber's orders and to eat healthy. Staff would report any high or low BG readings to the RN immediately and call 911 with any emergencies. -Medication Administration- R1 needed help taking medications including injectable medications. R1's mental health impacted their ability to take medications as prescribed. R1 needed support, encouragement, and assistance to consistently attend to their needs. R1 had a history of not following physician's orders as prescribed and/or becoming agitated and verbally aggressive by refusing to take their BG or allowing staff to check BG levels before meals and not seeking out staff support when needed. Staff would assist with medication management. Staff would keep all diabetic supplies in the	01760			

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01760	Continued From page 56 medication cart when not being used. R1 would like to do BG checks and insulin administration as prescribed with staff supervision. Staff instructed to supervise for safety, infection control, sharps safety, and to report any concerns to the RN. -Medication Management- The RN would be responsible for medication management and medication set up/reconciliation with providers and pharmacy as ordered by the prescriber. The RN would review/clarify any medication instructions from the prescriber that were not clear. -Self-Administration of Medications- Medication self-administration was not applicable. R1 has a history of not following physician's orders to take medications as prescribed, not taking insulin, or checking her BG levels resulting in poor management and hospitalizations. The assessment indicated R1 was independent with BG checks and insulin administration only with staff supervision. R1's Individualized Medication Management Plan dated July 20, 2024, indicated R1 was at risk for self-neglect and had a history of not following physician orders to take medications as prescribed and not taking insulin or checking BG levels resulting in poor management and hospitalizations. The medication management plan indicated R1 was assessed as not eligible for medication self-administration. R1's Individualized Treatment Management Plan as of August 13, 2024, indicated three times daily the HHA/RA would check and record R1's BG. The treatment management plan directed if BG was less than 70, give four (4) glucose tablets then notify the RN. In addition, the treatment management plan directed HHA/RA to notify the RN if BG was below 70 or above 300, or if R1	01760			

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01760	Continued From page 57 was shaking, sweating, had a headache, fatigue, or with any concerns. R1's Treatment Recap Summary dated July 2024 had a place for staff to document BG reading levels three times daily (AM, Midday, PM). AM Shift - 26 of 31 opportunities to document scheduled Record-Blood Glucose readings indicated ULPs had put their initials, and no BG test result was recorded; - 4 of 31 indicated R1 declined BG checks; and - 1 of 31 lacked documentation and was left blank. Midday Shift - 14 of 31 opportunities to document scheduled Record-Blood Glucose readings indicated ULPs had put their initials, and no BG test result was recorded; and - 17 of 31 indicated R1 declined BG checks. PM Shift - 20 out of 31 opportunities to document scheduled Record-Blood Glucose readings indicated ULPs had put their initials, and no BG test result was recorded; - 5 of 31 indicated R1 declined BG checks; and - 6 of 31 lacked documentation and was left blank. R1's Treatment Recap Summary dated August 2024 had a place for staff to document BG reading levels three times daily (AM, Midday, PM). AM Shift - 12 of 12 opportunities to document scheduled Record-Blood Glucose readings indicated ULPs had put their initials, and no BG test result was recorded;	01760			

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01760	Continued From page 58 Midday Shift - 7 of 12 opportunities to document scheduled Record-Blood Glucose order indicated ULPs had put their initials, and no BG test result was recorded; - 1 of 12 scheduled Record-Blood Glucose order indicated the value of BG test result; and - 4 of 12 indicated R1 declined BG checks. PM Shift - 11 of 12 opportunities to document scheduled Record-Blood Glucose order indicated ULPs had put their initials, and no BG test result was recorded; and - 1 of 12 indicated R1 declined BG checks. R1's After Visit Summary (AVS) dated November 17, 2023, from an emergency department visit for high blood sugar and abdominal pain included the following: - Stop - insulin glargine (Lantus SoloStar) (long-acting insulin) 100units/mL pen; and - Changed - Insulin aspart (fast-acting insulin) (NovoLog) 100units/mL FlexPen inject 6 units (u) under the skin three times a day before meals and 3 units before snacks; average daily dose of 27 units per day. In addition, the AVS directed to test BG twice daily, once fasting (before food) in the morning (AM) and once about two hours after the evening (PM) meal. The AVS did not contain a signature of the prescriber in accordance with section 151.01, subdivision 16a as noted in 144G.71 Subdivision 13. R1's AVS dated November 21, 2023, from emergency department visit for high blood sugar included the following:	01760			

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NAME OF PROVIDER OR SUPPLIER COMFORT CARE ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 414 EAST 26TH STREET MINNEAPOLIS, MN 55404		
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01760	Continued From page 59 - Changed - insulin glargine (Lantus SoloStar) 100units/mL pen, inject 22 units subcutaneously daily; and - Changed - insulin aspart (NovoLog) 100units/mL FlexPen inject 8 u under the skin three times a day before meals and 4 units before snacks. Use 1 u:50 >150 sliding scale based on BG measured PRIOR to meal - BG < 150 - no additional, BG 150-200 - add 1u, BG 201-250 - add 2u, BG 251-300 - add 3u, BG 301-350 add 4u, BG 351-400 - add 5u, BG over 400 -add 6u. Max daily dose 50u. In addition, the AVS directed to test BG twice daily, once fasting (before food) in the morning (AM) and once about two hours after the evening (PM) meal. The AVS did not contain a signature of the prescriber in accordance with section 151.01, subdivision 16a as noted in 144G.71 Subdivision 13. R1's AVS dated July 3, 2024, from a coordinated care visit for: nausea and vomiting included the following: - R1's BG level was 223 mg/dL (reference range 70-100); - Medication list (no change) - insulin glargine (Lantus SoloStar) 100 units/mL pen, inject 22 units subcutaneously daily; and - Medication list - insulin aspart (NovoLog) 100units/mL pen, inject 6 units subcutaneously three times daily before meals. Do not take if not eating. In addition, the AVS directed to test BG up to six times per day. The AVS did not contain a signature of the prescriber in accordance with section 151.01, subdivision 16a as noted in 144G.71 Subdivision 13.	01760			

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01760	Continued From page 60 R1's AVS dated July 11, 2024, from a coordinated care visit for: above reference range hemoglobin A1c (blood test that measures average BG levels over past two to three months), nausea and vomiting, and uncontrolled type 1 diabetes mellitus with hyperglycemia (high BG) included the following: - R1's Hemoglobin A1c level was 7.1% (reference range 4.0-5.6); - Medication list - insulin glargine (Lantus SoloStar) 100units/mL pen, inject 22 units subcutaneously daily; and - Medication list- insulin aspart (NovoLog) 100units/mL pen, inject 6 units subcutaneously three times daily before meals. Do not take if not eating. In addition, the AVS directed to test BG up to six times per day. The AVS did not contain a signature of the prescriber in accordance with section 151.01, subdivision 16a as noted in 144G.71 Subdivision 13. Although requested, the licensee did not provide the surveyor with any additional AVS'. Insulin glargine (Lantus SoloStar)-July 2024 R1's medication administration record (MAR) dated July 2024, directed staff to administer Lantus SoloStar 100u/mL injection daily. Instructions read: Inject 22 units subcutaneously daily every bedtime between the hours of 6:00 p.m., to 8:00 p.m., at the latest. The MAR directed staff to notify the registered nurse immediately per primary prescriber orders and indicated the medication was scheduled for administration at 7:00 p.m. -Staff documented declined or skipped administrations for the Lantus on eight of 31 occasions for the following reasons:	01760			

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01760	Continued From page 61 -Refused- resident not feeling well on seven occasions; and -Out of building on one occasion. R1's MAR contained no notes regarding whether staff alerted the RN of the missed doses. Insulin aspart (NovoLog)-July 2024 In addition, R1's MAR dated July 2024, indicated the following for NovoLog FlexPen 100u/mL: -NovoLog FlexPen 100u/mL Inject six units subcutaneously three times a day before breakfast, lunch, and dinner. The MAR did not include an administration time for the meal doses and had the medication listed with PRN (as needed) medications. -The MAR indicated the medication was administered on nine of 93 possible meal periods. R1's MAR dated July 2024, also contained the following for NovoLog FlexPen 100u/mL: -Take 4 units of NovoLog insulin with milk and a snack. The MAR did not include an administration time for the snack dosing and had the medication listed with PRN medications. According to R1's most recent two AVS' dated July 3, 2024, and July 11, 2024, this was not a current order. -The MAR indicated the medication dose was administered on nine occasions during the month of July 2024. Insulin glargine (Lantus SoloStar)-August 1-12, 2024 R1's MAR dated August 2024, directed staff to administer Lantus SoloStar 100u/mL injection daily. Instructions indicated: Inject 22 units subcutaneously daily every bedtime between the hours of 6:00 p.m., to 8:00 p.m., at the latest. The MAR directed staff to notify the registered nurse immediately per primary prescriber orders if the dose was missed and indicated the medication was scheduled for administration at 7:00 p.m.	01760			

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01760	Continued From page 62 -Staff did not document whether or not the medication was administered (left blank) on two of 12 occasions. R1's MAR contained no notes regarding whether staff alerted the RN of any missed doses. Insulin aspart (NovoLog)-August 1-12, 2024 In addition, R1's MAR dated August 2024, indicated the following for NovoLog FlexPen 100u/mL: -NovoLog FlexPen 100u/mL Inject 6 units subcutaneously three times a day before breakfast, lunch, and dinner. The MAR did not include an administration time for the meal doses and had the medication listed with PRN (as needed) medications. - The MAR indicated the medication was administered on four of 36 possible meal periods. R1's MAR dated August 2024, also contained the following for NovoLog FlexPen 100u/mL: -Take 4 units of NovoLog insulin with milk and a snack. The MAR did not include an administration time for the snack dosing and had the medication listed with PRN medications. According to R1's most recent two AVS' dated July 3, 2024, and July 11, 2024, this was not a current order. -The MAR indicated the medication dose was administered on four occasions from August 1-12, 2024. On August 13, 2024, at approximately 10:30 a.m., the surveyor observed R1's medication administration performed by unlicensed personnel/HHA/RA (ULP)-A. ULP-A administered oral medication to R1. The surveyor did not observe ULP-A perform a BG check or administer injectables to R1. On August 13, 2024, at 12:56 p.m., the surveyor requested to see signed physician orders for R1.	01760			

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01760	Continued From page 63 Clinical nurse supervisor (CNS)-C stated they did not have signed physician orders for R1 and stated the AVS' were the orders. On August 13, 2024, at 1:32 p.m., the surveyor showed R1's insulin order on R1's Medications - Current As of August 13, 2024, to CNS-C, and asked CNS-C to explain their understanding for R1's insulin administration order. CNS-C stated the order to give six units (NovoLog) was scheduled and the order to give four units (NovoLog) was as needed (PRN). The surveyor referred the CNS to the list where it indicated PRN for both orders and inquired how the ULPs would know how many units to give and when to give. CNS-C stated it was on the service plan. The surveyor observed CNS-C check the service plan and stated the order was not on there. CNS-C then stated the information was in the individual therapy and treatment plan. The surveyor observed CNS-C check the document and stated the order was not there. On August 13, 2024, at 1:36 p.m., housing manger/unlicensed personal (HM/ULP)-B stated they check R1's BG before and after meals. HM/ULP-B stated R1 mostly got four units of insulin, but if R1 ate a big meal they gave R1 six units of insulin. The surveyor inquired what was considered a big meal. HM/ULP-B explained, "let's say [R1] ate hamburger or fries, that is six units, if [R1] ate a slice of bread it is four units, if [R1] does not eat we do not give it to [R1] unless [R1's] blood sugar is over 300 then we give [R1] four units." On August 13, 2024, at 1:50 p.m., ULP-A stated they did not give insulin to R1 that morning because R1 did not eat.	01760			

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01760	Continued From page 64 On August 13, 2024, at 2:24 p.m., the surveyor inquired about CNS-C's expectation for how the ULPs would know how many units of insulin to give to R1. CNS-C explained for example if R1 eats half of their breakfast it is considered snack; R1 gets four units, and if R1 ate a full breakfast it was considered a meal and R1 gets six units of insulin, and staff do not give insulin if R1 does not eat. On August 13, 2024, at 2:27 p.m., CNS-C stated they did do BG checks when R1 allows them to do it and up to three times a day and PRN. The surveyor asked if they have documentation to show BG checks were done for R1. CNS-C stated it was documented in the MAR. The surveyor stated they did not see the BG results documented on the MAR. CNS-C stated it was also in the glucometer machine, it should be documented in the MAR, but "we do not micromanage." On August 13, 2024, at 3:03 p.m., ULP-A stated they check R1's BG level and chart it in the computer. ULP-A stated if the BG was high, they give insulin. The surveyor inquired what was considered high BG. ULP-A stated 170, 180, 200 or above, if R1 ate a lot of food, R1 gets six units if R1 ate small food they get four units, but usually, R1 got six units. On August 15, 2024, at 2:15 p.m., the surveyor requested CNS-C provide all nursing progress notes for R1 for the entire year of 2024. On August 15, 2024, at 2:40 p.m., CNS-C stated they used two different pharmacies for R1's medication supply and stated they get NovoLog from [pharmacy #1] and Lantus and all oral meds from [pharmacy #2].	01760			

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01760	Continued From page 65 On August 15, 2024, at 3:47 p.m., via email CNS-C provided R1's nursing notes for October, November, and December 2023. CNS-C provided no notes for 2024. On August 15, 2024, at 4:02 p.m., pharmacist from [pharmacy #2] stated they had the following orders for R1: - NovoLog FlexPen 12 units, three times daily before meals and six units before snacks. Maximum daily dose 50 units ordered January 12, 2024. Last refilled April 26, 2024; and - Stop Lantus ordered December 27, 2023. On August 15, 2024, at 4:13 p.m., pharmacist from [pharmacy #1] stated they had the following orders for R1: - NovoLog FlexPen six units three times a day before meal. Do not take insulin if not eating. Order written on May 8, 2024. Insulin last filled by pharmacy December 2023. - Lantus inject 22 units subcutaneously once daily. Order written on December 27, 2023. Last filled by pharmacy on July 6, 2024. R1's most current insulin orders were not accurately reflected on R1's July or August 2024 MARs. The licensee did not ensure the licensed nurse maintained signed provider's orders, updated R1's records to reflect changes when made, reconciled medication discrepancies between pharmacy medication labels and AVS', or ensured staff appropriately supervised insulin administration or administered insulin accurately. In addition, based on interviews, CNS-C delegated nursing assessment tasks to ULP's when the ULP's were required to determine insulin doses based on evaluating whether what the resident ate was considered a snack or a	01760			

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01760	Continued From page 66 meal, instead of specifically following the prescriber's order. The licensee's Prescriber's Orders policy dated May 2, 2020, read, "1. Written orders from an authorized prescriber will be obtained for all medications and treatments with which the home health [the licensee's name] Assisted Living assists clients, including over the counter medications. 2. Verbal orders may be accepted by a nurse who records and signs the order and then forwards it to the prescriber for signature no later than seven days after receipt of the verbal order. 3. Telephone, facsimile, or computer-generated orders will be kept confidential. An order received by facsimile must have been signed by the prescriber and a durable copy placed in the clinical record by home care staff. 4. All orders must be signed and dated by the prescriber. If the prescriber omitted a date, the [licensee's name] Assisted Living will date the order when received from the prescriber. 5. Medication orders will include the name of the medication, dosage, and directions for use. 6. The Registered Nurse is responsible for implementing medication and treatment orders or for delegating the orders to the appropriate paraprofessional. 7. Medication and treatment orders will be renewed at least every year or when changes occur." TIME PERIOD FOR CORRECTION: Immediate The immediacy of order with tag identification 1760 was not removed prior to survey exit on August 16, 2024.	01760			

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01820	Continued From page 67	01820			
01820 SS=D	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 interview and record review, the licensee failed to maintain current medication orders for one of three residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted to the facility on October 31, 2023. R1's diagnoses included, schizoaffective disorder, cannabis use disorder, intellectual disability post-traumatic stress disorder schizophrenia, diabetes mellitus, hypertension, hyperlipidemia, history of malnutrition, and personality disorder. R1's service plan dated July 29, 2024, indicated R1 received medication administration three time per day, R1's medication administration record (MAR)	01820			

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01820	Continued From page 68 dated August 1, 2024, through August 13, 2024, indicated R1 received the following scheduled medication medications: -pantoprazole 40 milligram (mg) tablet (tab) daily, -Abilify 400 mg injection every three weeks, -ammonium lactate 12 percent (%) cream twice daily, -senna plus 8.6-50 mg tab twice daily, -amlodipine 10 mg tab daily, -aripiprazole 10 mg tab daily, -ferrous sulfate 324 mg enteric coated (EC) tab Monday, Wednesday, and Friday, -lisinopril 30 mg tab daily, -pregabalin 75 mg capsule (cap) twice daily, -vitamin D3 25 microgram (mcg) caps daily, -divalproex 500 mg extended release (ER) 3 tabs daily at bedtime (HS), -Lantus Solostar 100 units (u)/milliliter (ml) inject daily 22 units daily at HS, -melatonin 3 mg tab daily at HS, and -simvastatin 20 mg tab daily. The MAR also indicated R1 received the following as needed (PRN) medications: -glucose tab orange 4 tabs, -Novolog FlexPen 100 u/ml 6 u three times a day, -Novolog FlexPen 100 u/ml inject 4 u with milk and snack, -polyethylene glycol 3350 powder 17 grams(g) daily, -acetaminophen 500 mg 1 tab every four hours, -diclofenac 1% gel 2 g four times daily, -hydroxyzine 25 mg tab, one to two tablets three times daily, -ondansetron 4 mg three times daily, and -Pepto-Bismol 262/15 ml suspension 15 ml one time. On August 13, 2024, at 12:56 p.m., the surveyor requested to see signed physician orders for R1. Clinical nurse supervisor (CNS)-C stated they did	01820			

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01820	Continued From page 69 not have signed physician orders for R1 and stated the AVS' were the orders. The licensee's Medication Administration Policy dated May 5, 2020, indicated the licensed nurse was responsible for assessing medications to assure that all medications are current and ordered by the prescriber and to identify any expired or outdated medications are disposed of according to the license's policy. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820			
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure time sensitive medications were labeled with the date opened for one of three residents (R1) and failed to discard unused medication 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	01890			

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01890	Continued From page 70 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 the potential to affect a large portion or all of the residents). The findings include: NO OPENED-ON DATE R1 was admitted on October 31, 2023. R1's diagnoses included schizoaffective disorder, cannabis use disorder, intellectual disability post-traumatic stress disorder schizophrenia, diabetes mellitus, hypertension, hyperlipidemia, history of malnutrition, and personality disorder. R1's service plan dated July 29, 2024, indicated R1 received medication administration three time per day, record blood glucose assistance three time per day, and supervision for record-blood glucose by the registered nurse (RN) one day a week. On August 13, 2024, at 2:49 p.m., the surveyor observed R1's insulin pens. Unlicensed personnel (ULP)-A had the insulin pens in their purse. ULP-A stated they took the insulin pens with them to the mall so they can give it to R1 in case R1 ate at the mall. The surveyor observed the following time sensitive insulin pen was opened without an opened on date label and without resident identifier label: - R1's Novolog FlexPen. On August 13, 2024, at 3:00 p.m., clinical nurse supervisor (CNS-C) stated they did not know why the insulin pen was not labeled. The manufacturer's instructions for the use of	01890			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35884	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2024
NAME OF PROVIDER OR SUPPLIER COMFORT CARE ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 414 EAST 26TH STREET MINNEAPOLIS, MN 55404		
(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
01890	Continued From page 71 Novolog (insulin aspart) injection FlexPen last revised February 2023, directed the insulin aspart to be discarded after 28 days, even if it still has insulin left in it. The licensee's Storage/Control of Medications policy dated May 5, 2020, indicated the licensed nurse was responsible for dating time-sensitive medications for use. OUTDATED MEDICATION The licensee's Current Client Roster: Comprehensive (144A) dated August 1, 2020, to August 12, 2024, indicated R3 was admitted to the licensee on May 25, 2024. R3's diagnosis included schizoaffective disorder, bipolar disorder, anxiety, major depressive disorder, delusion, and chronic right shoulder pain. R3's unsigned Service Plan (Waiver) - Addendum to Contract, dated August 15, 2024, did not indicate R3 received medication management services. On August 12, 2024, at 11:30 a.m., during facility tour, the surveyor observed two yellow medication bottles with white caps in the last drawer of the medication cabinet located in the basement. CNS-C stated they did not know what the medications were, and they did not know whose medication they were. The sticker label on the medication bottle was faded/removed, however the surveyor was able to read R3's name on the bottle. The first bottle had white round pills with imprints. The second bottle has round yellow pills with imprints, indicating the first medication bottle contained risperidone 1milligram (mg) and the second bottle contained	01890			

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01890	Continued From page 72 risperidone 2 mg. On August 12, 2024, at approximately 11:30 a.m., CNS-C stated, "it is a medication that no one is taking and that is why I put it in there [referring to the last drawer]." Surveyor observed R3's name in faint print and asked CNS-C if that was R3's name and asked if that was the name of a person who resided at the facility currently. CNS-C confirmed the name and stated they were a current resident of the facility. CNS-C also stated R3 was not taking the medication, and no one was supposed to take these medications. Surveyor inquired to know why the medications were not disposed of. CNS-C stated they came back on duty on July 15, 2024, and stated "it was supposed to be destroyed by the previous nurse; now I am taking the responsibility". The licensee's Medication Administration Policy dated May 5, 2020, indicated the licensed nurse was responsible for assessing medications to assure that all medications are current and ordered by the prescriber and to identify any expired or outdated medications are disposed of according to the license's policy. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a	01910			

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01910	Continued From page 73 resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide documentation of disposition of medications for one of one discharged resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The licensee's Discharge Resident/Client roster dated August 1, 2020, to August 12, 2024, indicated R2 was admitted to the licensee on November 1, 2022, and discharged on February	01910			

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01910	Continued From page 74 28, 2024. R2's diagnoses included schizoaffective disorder, bipolar disorder, border line personality disorder behavioral disturbances, post-traumatic stress disorder, and noncompliance with medication. R2's record included a Discharge - Transfer Summary completed by clinical nurse supervisor (CNS)-C on March 12, 2024. The discharge transfer summary indicated R2 was receiving medication administration services and took the following medications: Abilify 400 milligram (mg) injection, fluphenazine 2 mg/milliliter (ml) injection, vitamin D3 25 micrograms (mcg) tablet, and acetaminophen 325 mg tablet. R2's record lacked evidence of documented disposition of medications for R2 to include: the name of the medication, strength, prescription number if applicable, quantity, to whom the medications were given, date of disposition, and the names of the staff and other individuals involved in the disposition. On August 13, 2024, at 3:03 p.m., the surveyor requested the medication disposition policy. CNS-C stated "it depends, we give it to them [referring to the residents] or family and if they do not want it, we put it in the drug buster and we document it in Rtask [electronic medication administration records software]." CNS-C then provided the surveyor with the discharge transfer summary document mentioned above. The Medication Disposition Summary section of the discharge transfer summary document was not completed. The licensee's Medication Administration Policy dated May 5, 2020, indicated the licensed nurse	01910			

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01910	Continued From page 75 was responsible for assessing medications to assure that all medications are current and ordered by the prescriber and to identify any expired or outdated medications are disposed of according to the license's policy. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910			
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the required notice was posted at the main entryway of the facility to display statutory language to disclose electronic monitoring activity. This had the potential to affect all of the licensee's residents, staff, and visitors. This practice resulted in a level one violation (a violation that has not 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 the residents).	03090			

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03090	Continued From page 76 The finding include: On August 12, 2024, at 9:49 a.m., the surveyor observed a sign posted at the main entrance indicating the area was under 24 hours video surveillance. The sign did not include a statement to indicate electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities. On August 12, 2024, at 10:38 a.m., clinical nurse supervisor (CNS)-C stated they were not responsible for the postings. CNS-C stated licensed assisted living director (LALD)-D did the postings. On August 14, 2024, at 2:42 p.m., LALD-D stated they had the right sign with the right verbiage posted on the door, and stated, "sometimes resident [sic] takes it off, I knew we had the right one." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090			

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Food and Beverage Establishment Inspection Report

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Location:

Comfort Care Assisted Living
414 East 26th Street
Minneapolis, MN55404
Hennepin County, 27

Establishment Info:

ID #: 0038145
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6122364212
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.

2-200 Employee Health

2-201.11C

**** Priority 1 ****

MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority at the specific request of the regulatory authority.

NO ILLNESS LOG PRESENT AT ESTABLISHMENT. EXAMPLE MDH ILLNESS LOG PROVIDED AND EXPLAINED DURING INSPECTION.

Comply By: 08/13/24

3-500D Microbial Control: disposition of food

3-501.18A

**** Priority 1 ****

MN Rule 4626.0405A Discard all TCS food prepared in the establishment or opened commercially packaged food when the time exceeds 7 days from the preparation or opening date or if the container or package is not marked.

OBSERVED LEFTOVER RICE AND CHICKEN PASTA IN THE MAIN KITCHEN FRIDGE AND CHILI IN THE BASEMENT FRIDGE WITH NO MARKING. ITEMS DISCARDED ON SITE.

Corrected on Site

3-500C Microbial Control: date marking

3-501.17B

**** Priority 2 ****

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

OBSERVED AN OPENED CONTAINER OF TURKEY AND BAG OF CHEESE IN THE KITCHEN

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FRIDGE WITH NO DATE MARKING. ISSUE CORRECTED ON SITE.

Corrected on Site

4-300 Equipment Numbers and Capacities

4-302.12B **** Priority 2 ****

MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.

ESTABLISHMENT HAS ITEMS SUCH AS SALMON, BEEF & CHICKEN ON THE MENU AND THERE WAS NO FOOD THERMOMETER ON SITE FOR CHECKING INTERNAL TEMPERATURE OF COOKED FOOD. COMPLY WITH ABOVE RULE.

Comply By: 09/03/24

4-300 Equipment Numbers and Capacities

4-302.13B **** Priority 2 ****

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

NO DEVICE AS INDICTED ABOVE WAS AVAILABLE FOR MEASURING THE UTENSIL SURFACE TEMPERATURE OF KITCHEN DISH MACHINE. MDH PROVIDED A COUPLE THEMOLABEL STICKERS UNTIL SOME CAN BE OBTAINED.

Comply By: 09/03/24

5-200C Plumbing: Maintenance, fixture location

5-205.11AB **** Priority 2 ****

MN Rule 4626.1110AB The handwashing sink must be accessible at all times for employee use, and must be used only for handwashing.

NO BASIN IN THE 2 COMPARTMENT SINK WAS DESIGNATED FOR HANDWASHING ONLY. COMPLY WITH ABOVE RULE.

Comply By: 09/03/24

3-300B Protection from Contamination: cross-contamination, eggs

3-302.12

MN Rule 4626.0240 Properly label all working containers holding food or food ingredients that are removed from original packages with the common name of the food. Label the food in English and any other languages used by employees who handle food.

OBSERVED AN UNLABELED CONTAINER STORING A SEASONING INGREDIENT IN THE CABINET JUST TO THE LEFT OF SINK AND A ZIPLOCK BAG IN THE FREEZER WITH NO IDENTITY LABEL. ADVISED STAFF TO ALWAYS LABEL FOOD REMOVED FROM ORIGINAL PACKAGE AS REQUIRED BY ABOVE RULE.

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3-300C Protection from Contamination: equipment/utensils, consumers

3-305.11A

MN Rule 4626.0300A Store all food in a clean, dry location; where it is not exposed to splash, dust or other contamination; and at least 6 inches above the floor.

OBSERVED FOOD BEING STORED DIRECTLY ON THE FLOOR IN THE CORNER OF THE KITCHEN. COMPLY WITH ABOVE RULE.

Comply By: 09/03/24

4-100 Equipment Construction Materials

4-101.11BCDE

MN Rule 4626.0450BCDE Remove all multi-use equipment, utensils, and food storage containers that are not durable, corrosion-resistant, nonabsorbent, smooth, easily cleanable, resistant to pitting, chipping, scratching or not able to withstand repeated warewashing.

OBSERVED BROWN SUGAR BEING STORED IN A GLASS STORAGE CONTAINER WITH SEVERAL CRACKS/CHIPS ALONG THE EDGE. ADVISED TO DISCARD CONTAINER AND CONTENTS.

Comply By: 08/13/24

4-100 Equipment Construction Materials

4-101.17

MN Rule 4626.0490 Discontinue using wood and wood wicker as a food contact surface.

OBSERVED HEAVILY SCORED WOOD CUTTING BOARDS IN THE KITCHEN DRAWER. ADVISED TO DISCONTINUE USE.

Comply By: 09/03/24

4-100 Equipment Construction Materials

4-101.19

MN Rule 4626.0495 Remove non-food-contact surfaces of equipment that are exposed to splash, spillage, or other food soiling, or that require frequent cleaning, that are not constructed of a corrosion-resistant, non-absorbent, and smooth material.

OBSERVED SOILED AND RIPPED TIN FOIL COVERING THE SHELVING IN THE LAZY SUSAN TURN AROUND. COMPLY WITH ABOVE RULE.

Comply By: 09/03/24

4-600 Cleaning Equipment and Utensils

4-602.12

MN Rule 4626.0850 Clean the food contact surfaces of cooking and baking equipment and interior cavities of microwave ovens at least every 24 hours.

OBSERVED SPLATTERED FOOD RESIDUE INSIDE THE MICROWAVE AND OVEN. COMPLY WITH ABOVE RULE.

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6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.12A

MN Rule 4626.1520A Clean and maintain all physical facilities clean.

OBSERVED FOOD CRUMBS/DEBRIS IN DRAWERS AND CABINETS THROUGHOUT THE KITCHEN.
CLEAN AT A GREATER FREQUENCY TO PREVENT SUCH ACCUMULATION.

Comply By: 09/03/24

Surface and Equipment Sanitizers

UTENSIL SURFACE TEMP: = at 150 Degrees Fahrenheit

Location: DISH MACHINE

Violation Issued: No

Chlorine: = 100PPM at Degrees Fahrenheit

Location: SANITIZER

Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Hold/CREAM

Temperature: 40 Degrees Fahrenheit - Location: KITCHEN FRIDGE

Violation Issued: No

Process/Item: Ambient Temp

Temperature: 39 Degrees Fahrenheit - Location: KITCHEN FRIDGE

Violation Issued: No

Process/Item: Ambient Temp

Temperature: 0 Degrees Fahrenheit - Location: CHEST FREEZER

Violation Issued: No

Process/Item: Cold Hold/HOT DOG

Temperature: 40 Degrees Fahrenheit - Location: BASEMENT FRIDGE

Violation Issued: No

Process/Item: Ambient Temp

Temperature: 38 Degrees Fahrenheit - Location: BASEMENT FRIDGE

Violation Issued: No

Process/Item: Ambient Temp

Temperature: 2 Degrees Fahrenheit - Location: BASEMENT FREEZER

Violation Issued: No

Total Orders	In This Report	Priority 1	Priority 2	Priority 3
		2	4	7

THIS INSPECTION WAS CONDUCTED IN CONJUNCTION WITH MDH HEALTH REGULATORY DIVISION (HRD) SURVEY. SURVEYOR FROM HRD WAS DEE MOSSA. INSPECTION CONDUCTED IN PRESENCE OF NIMO AHMED, THE PERSON IN CHARGE. AT TIME OF INSPECTION, ESTABLISHMENT HAD THREE RESIDENTS. ALL VIOLATIONS WERE DISCUSSED WITH THE SURVEYOR AND PERSON IN CHARGE DURING INSPECTION.

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THIS FACILITY DOES NOT HAVE COMMERCIAL GRADE ANSI EQUIPMENT. ALL FOOD MUST BE SERVED THE SAME DAY IT IS PREPARED, AND LEFTOVERS CAN NEVER BE SAVED.

FOOD SERVICE AREA FLOORS, WALLS, CEILINGS, COUNTERTOPS, AND FINISH MATERIALS MUST BE NON-ABSORBANT, SMOOTH, DURABLE, AND EASILY CLEANABLE. CEILINGS CANNOT HAVE POPCORN TEXTURE. CABINETS CANNOT HAVE HOLLOW BASES. EXPOSED WOOD IS NOT APPROVED FOR FOOD SERVICE AREAS. WOOD IS NOT AN APPROVED FOOD CONTACT SURFACE.

DISCUSSED ALL ORDERS ON SITE IN ADDITION TO THE FOLLOWING WITH THE PERSON IN CHARGE:

- EMPLOYEE ILLNESS LOG AND EXCLUSION POLICY.
- HAND WASHING POLICY AND REVIEW.
- PROPER FOOD STORAGE.
- GLOVE USAGE.
- THERMOMETER USE AND CALIBRATION.
- SANITIZER USE AND TEST KITS.
- DATE MARKING.
- PEST CONTROL.
- FULLY COOKING FOOD FOR HIGH RISK POPULATIONS.
- ANSI 184 STANDARD FOR RESIDENTIAL DISH WASHER.

FOR CORRECT BY DATES REFER TO COMPLETE REPORT ISSUED BY HRD.

****IF ANY RESIDENT COMPLAINS OF ILLNESS, CONTACT THE MINNESOTA DEPARTMENT OF HEALTH AND PROVIDE THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER TO THE CUSTOMER. THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER IS 1-877-366-3455.**

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

I acknowledge receipt of the inspection report number 1036241157 of 08/13/24.

Certified Food Protection Manager BALIQISA HASSAN

Certification Number: FM107755 Expires: 09/13/24

Inspection report reviewed with person in charge and emailed.

Signed: _____

NIMO AHMED
PERSON IN CHARGE

Signed: _____

Jeff Johanson