Electronically Delivered

February 27, 2025

Licensee
Urbana Place Senior Living
5601 94th Avenue North
Brooklyn Park, MN 55443

RE: Project Number(s) SL35230016

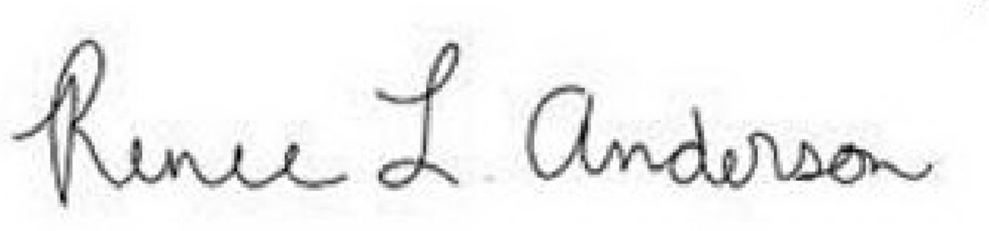
Dear Licensee:

On January 23, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the November 7, 2024, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,



Renee L. Anderson, Supervisor
State Evaluation Team
Email: Renee.L.Anderson@state.mn.us
Telephone: 651-201-5871 Fax: 1-866-890-9290

HHH

Electronically Delivered

December 13, 2024

Licensee
Urbana Place Senior Living
5601 94th Avenue North
Brooklyn Park, MN 55443

RE: Project Number(s) SL35230016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on November 7, 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:

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

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

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

The correction order documentation should include the following:

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

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

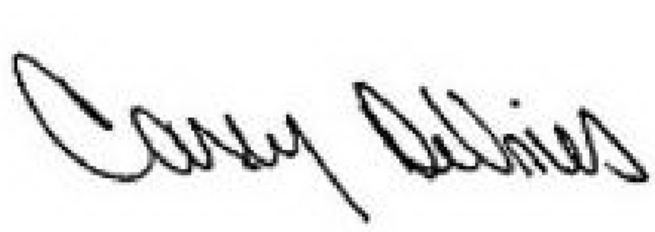
the website listed above.

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,



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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35230	A. BUILDING: _____ B. WING _____	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
URBANA PLACE SENIOR LIVING	5601 94TH AVENUE NORTH BROOKLYN PARK, MN 55443

(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: SL35230016-0 On November 4, 2024, through November 7, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction are issued. At the time of the survey there were 104 residents residing at the facility, 90 of those residents received assisted living services. An immediate correction order was identified on October 21, 2024, issued for SL36204016-0, tag identification 2310. The licensee took action to mitigate the immediate risk, however, noncompliance remained, and the scope and level remained unchanged.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Home Care 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 144A.474 SUBDIVISION 11 (b)(1)(2).	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470		

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0 470	Continued From page 1 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 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 interview and record review, the licensee failed to ensure their staffing plan was updated at least twice annually which had to potential to affect all staff, residents, and volunteers. 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	0 470		

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0 470	Continued From page 2 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 Contingency Staffing Plan, undated, included the required staffing plan content but did not indicate when it was last reviewed or updated. On November 4, 2024, at 9:47 a.m., during the entrance conference, clinical nurse supervisor (CNS)-A stated they had a staffing plan but was unsure how often it was required to be updated. On November 6, 2024, at 12:58 p.m., licensed assisted living director (LALD)-D stated they were unsure when the staffing plan was updated and did not have documentation of when it was last updated. LALD-D stated they would fix it going forward with CNS-A. LALD-D stated they thought it needed to be updated annually. On November 6, 2024, at 1:24 p.m., CNS-A stated they were not sure how often their staffing plan was required to be updated, they thought maybe every 30 days. The licensee's Staffing Requirements policy updated in December 2022, indicated, "DHS/Clinical Nurse Supervisor must develop and implement a written staffing plan that provides an adequate number of qualified direct care staff to meet the residents needs 24 hours a day, seven days per week," but did not indicate the staffing plan frequency of review or update.	0 470		

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0 470	Continued From page 3 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post the facility's grievance procedure with the name, telephone number, and email contact information for the individuals responsible for handling resident grievances. 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	0 550		

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0 550	Continued From page 4 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 November 4, 2024, at 10:46 a.m., during the facility tour with clinical nurse supervisor (CNS)-A, the surveyor observed the facility postings in the main lobby; there was a grievance form and drop box but the form and posting lacked the name, telephone number, and email contact information for the individuals responsible for handling resident grievances. CNS-A stated the information was not posted. Director of Sales and Marketing (DSM-E) stated the contact person was not on their grievance form but once the grievance form was filled out it went to the appropriate person who handled grievances. On November 6, 2024, at 8:20 a.m., licensed assisted living director (LALD)-D stated they were aware the grievance contact information was required to be posted. LALD-D stated they only started working at the facility two days ago and would need to look into why the grievance contact information was not posted. On November 6, 2024, at 3:25 p.m., regional director of operations (RDO)-G showed the surveyor another posting down a hallway from the main lobby and stated they thought the required grievance contact information might be posted on a bulletin board. The surveyor observed the bulletin board which lacked the required contact information. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 550		

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0 550	Continued From page 5 (21) days	0 550		
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 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 comply with the current State Fire Code in Minnesota Rules, chapter 7511. This had the potential to directly affect all residents, staff, and visitors.	0 780		

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0 780	Continued From page 6 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 November 6, 2024, from 10:30 a.m. to 2:30 p.m., the surveyor toured the facility with director of maintenance (DOM)-I and regional maintenance director (RMD)-J. DOM-I left the tour at 11:00 a.m. The following deficient conditions were observed: TRASH AND RECYCLING CHUTES The recycling chute doors on the first and fourth floors did not shut and latch on their own. The trash chute doors on the first and second floors did not shut and latch on their own. All recycling and trash chute doors should close and latch completely to maintain the fire resistance integrity of the trash chute system. All trash and recycling chute doors were not installed flush to the wall. Gapping around the installation can compromise the fire resistance rating of the trash chute system. FIRE-RATED DOOR OPERATION AND LOCKING The electrical room door adjacent to the elevator lobby in the garage did not close and latch on its own. Fire-rated doors to high-hazard areas shall close from the full-open position and latch automatically to maintain the fire resistance	0 780		

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0 780	Continued From page 7 integrity of the assembly. All the egress stairwell doors outside the secured memory care unit were equipped with electromagnetic locks. RMD-J stated the locks would drop upon activation of the fire alarms and sprinkler system and would need to be manually re-engaged using the button adjacent to each door after alarm activation. The egress control locking system, at the stairwell doors, shall have the capability of being unlocked by a signal or switch from the fire command center, a nursing station, or other approved location. The signal or switch shall directly break power to the lock. RMD-J stated they did not know of a central location where the locks could be disengaged. 24-hour resident or patient supervision was not provided within all the secured areas. LIFE SAFETY SYSTEM MAINTENANCE The fire alarm system was last inspected on March 23, 2022. Fire alarm and automatic fire-extinguishing systems shall be inspected and tested at least annually. RMD-J visually verified these deficient findings at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the	0 800		

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0 800	Continued From page 8 residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the 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. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On November 6, 2024, from 10:30 a.m. to 2:30 p.m., the surveyor toured the facility with director of maintenance (DOM)-I and regional maintenance director (RMD)-J. DOM-I left the tour at 11:00 a.m. The following deficient conditions were observed: GENERAL MAINTENANCE: The exit door adjacent to the exercise area in the locked memory care unit did not close and latch on its own. The patio gate for the memory care secured patio	0 800		

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0 800	Continued From page 9 did not unlock when the code was entered into the code pad. RMD-J stated the code pad and lock had been disabled at some point and did not function. The wall of stairwell C going into the basement had significant water damage. The paint was bubbling and peeling along the entire length of the wall. RMD-J visually verified these deficient findings at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for 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.	0 810		

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0 810	Continued From page 10 (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On November 6, 2024, director of maintenance (DOM)-I and licensed assisted living director (LALD)-D provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility.	0 810		

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	35230	A. BUILDING: _____ B. WING _____	11/07/2024

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0 810	Continued From page 11 FIRE SAFETY AND EVACUATION PLAN The licensee's FSEP failed to include the following: The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation nor did it include instructions for staff to follow in case of relocation. On November 6, 2024, at 3:30 p.m., LALD-D stated they would work on bringing the incomplete sections of their policy into compliance. TRAINING: The licensee failed to provide evacuation training to residents at least once per year. LALD-D lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan. The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. The licensee's training records, titled "Coarse Completion History", dated November 6, 2024, indicated staff were trained once per year using a training program titled "Spark School Annual Training for Everyone". There was no documentation provided that indicated the training program include fire safety and evacuation training for the facility specific evacuation plan. No other training documentation was provided.	0 810		

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0 810	Continued From page 12 On November 6, 2024, at 3:30 p.m., LALD-D stated they were new to the role and had not had an opportunity to implement a complete training program for residents and staff and were working on developing a training program that was compliant with statute requirements. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01610 SS=D	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 ensure the registered nurse (RN) completed an initial comprehensive nursing assessment on, or before, the date of admission	01610		

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01610	Continued From page 13 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) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R3 was admitted to the licensee on October 28, 2022, as an independent living (IL) resident. R3 later began receiving assisted living (AL) services on January 21, 2023. R3's Service Addendum to the Assisted Living Contract form dated November 6, 2024, unsigned, indicated R3 received services for bathing, monthly vital signs, injections, and safety checks for bed rails. R3's Nursing Assessment dated January 21, 2023, was an incomplete comprehensive admission assessment and lacked the following required comprehensive assessment information: -the resident's personal lifestyle preferences; -activities of daily living, including; -independent instrumental activities of daily living; -physical health status; -emotional and mental health conditions; -pain; -skin conditions; -nutritional and hydration status and preferences; -list of treatments, including type, frequency, and level of assistance needed; -nursing needs, including potential to receive nursing-delegated services;	01610		

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01610	Continued From page 14 -risk indicators; -who has decision-making authority for the resident; and -the need for follow-up referrals for additional medical or cognitive care. On November 6, 2024, at 11:26 a.m., regional director of nursing (RDN)-F stated R3 was admitted to the licensee as an IL resident on October 28, 2022, and then admitted to AL on January 21, 2023. On November 6, 2024, at 11:53 a.m., RDN-F stated the January 21, 2023, admission assessment to AL was not a comprehensive nursing assessment. RDN-F stated it should have been completed as a comprehensive assessment. On November 6, 2024, at 1:24 p.m., clinical nurse supervisor (CNS)-A stated they were aware of R3's incomplete comprehensive nursing assessment from R3's admission to AL; they stated it should have been comprehensive. CNS-A stated they were working for the licensee on an interim basis to assist the previous CNS, but then the CNS quit. CNS-A stated they were not working for the licensee when the assessment was completed and did know why it was an incomplete assessment. CNS-A stated they were working on fixing the licensee's assessment process. The licensee's Minnesota Clinical Assessment Guide - AL and MC assessment schedule dated May 2024, indicated a pre-admission assessment was required for AL and memory care (MC) residents, then within 14 days after the admission date and every 90 days after.	01610		

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01610	Continued From page 15 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 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 observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted a comprehensive assessment within 14 days of the	01620		

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01620	Continued From page 16 initiation of services 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, 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 was admitted to the licensee on March 1, 2024. R2's Service Addendum to the Assisted Living contract dated November 5, 2024, unsigned, indicated R2 received services for medication management, bathing, toileting, escort, laundry, and dressing. On November 5, 2024, at 8:12 a.m., the surveyor observed unlicensed personnel (ULP)-B administer medications to R2. R2's admission Nursing Assessment was completed on February 26, 2024. R2's 14-day Nursing Assessment was completed on March 18, 2024, seventeen days past R2's date of admission on March 1, 2024. R3 R3 was admitted to the licensee on October 28, 2022, as an independent living (IL) resident. R3 later began receiving assisted living (AL) services	01620		

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01620	Continued From page 17 on January 21, 2023. R3's Service Addendum to the Assisted Living Contract form dated November 6, 2024, unsigned, indicated R3 received services for bathing, monthly vital signs, injections, and safety checks for bed rails. R3's Nursing Assessment dated January 21, 2023, was an incomplete comprehensive admission assessment. R3's record lacked a 14-day comprehensive assessment. On November 6, 2024, at 11:53 a.m., RDN-F stated a 14-day assessment was not completed for R3. On November 6, 2024, at 1:24 p.m., clinical nurse supervisor (CNS)-A stated they were aware R3 was missing a 14-day assessment. CNS-A stated they were working for the licensee on an interim basis to assist the previous CNS, but then the CNS quit. CNS-A stated they did not know why it was not completed. CNS-A stated they were working on fixing the licensee's assessment process. The licensee's Minnesota Clinical Assessment Guide - AL and MC assessment schedule dated May 2024, indicated a pre-admission assessment was required for AL and memory care (MC) residents, then within 14 days after the admission date and every 90 days after. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		

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01630	Continued From page 18	01630		
01630 SS=D	144G.70 Subd. 3 Temporary service plan When a facility initiates services and the individualized assessment required in subdivision 2 has not been completed, the facility must complete a temporary plan and agreement with the resident for services. A temporary service plan shall not be effective for more than 72 hours. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to complete a temporary service plan as required at the time of admission for one of three residents (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 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: R2 was admitted to the licensee on March 1, 2024. R2's Service Addendum to the Assisted Living contract dated November 5, 2024, unsigned, indicated R2 received services for medication management, bathing, toileting, escort, laundry, and dressing. R2's record lacked a signed service plan. On November 5, 2024, at 8:12 a.m., the surveyor observed unlicensed personnel (ULP)-B	01630		

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01630	Continued From page 19 administer medication to R2. On November 5, 2024, at 11:43 a.m., regional director of nursing (RDN)-F stated R2 did not have a signed service plan in their record. On November 6, 2024, at 9:59 a.m., RDN-F stated they could not find a signed service plan at all for R2 which included one completed at the time of their admission. On November 6, 2024, at 1:24 p.m., clinical nurse supervisor (CNS)-A stated the nurse who completed an assessment for the resident was responsible for creating and updating service plans. CNS-A stated service plans were required to be created at the time of admission, when there is a change to the resident's needs, and yearly. CNS-A stated they were working for the licensee on an interim basis to assist the previous CNS, but then the CNS quit. CNS-A stated they were not working for the licensee when R2 was admitted so they could not say whether it was completed at the time of admission. CNS-A stated they were currently trying to fix service plan issues. The licensee's Service Plan Guideline dated September 2023, indicated: "All services provided to clients will be delivered after an assessment by an RN is completed, an up-to date Service Plan is signed by an RN and the client or the client ' s designated representative. -Service Addendum to the Assisted Living Contract shall be signed on day of admission." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	01630		

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01630	Continued From page 20 (21) days	01630		
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to obtain a resident or resident representative's signature documenting agreement on the services to be provided when a change was made to services and the service plan for three of three residents (R2, R3, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01640		

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01640	Continued From page 21 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 was admitted to the licensee on March 1, 2024. R2's Service Addendum to the Assisted Living contract dated November 5, 2024, unsigned, indicated R2 received services for medication management, bathing, toileting, escort, laundry, and dressing. On November 5, 2024, at 8:12 a.m., the surveyor observed unlicensed personnel (ULP)-B administer medication to R2. R2's record lacked a signed service plan. R3 R3 was admitted to the licensee on October 28, 2022, as an independent living resident. R3 began receiving services from the licensee on January 21, 2023. R3's Service Addendum to the Assisted Living Contract form dated May 16, 2023, indicated R3 received services for bathing, monthly vital signs, and incidental nursing. R3's Service Addendum to the Assisted Living Contract form dated November 6, 2024, unsigned, indicated R3 received services for bathing, monthly vital signs, injections, and safety	01640		

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01640	Continued From page 22 checks for bed rails. R3's record lacked a current signed service plan. R4 R4 was admitted to the licensee on June 12, 2023. R4's Service Addendum to the Assisted Living Contract form dated November 21, 2023, indicated R4 received services for laundry, toileting, escort assistance, trash removal, dressing, weekly weights, monthly vital signs, and safety checks for bed rails. R4's Service Addendum to the Assisted Living Contract form dated November 5, 2024, unsigned, indicated R4 received services for grooming, medication assistance, bathing, laundry, toileting, escort assistance, monthly vital signs, trash removal, safety checks for bed rails, safety checks, dressing, and weekly weights. On November 5, 2024, at 8:35 a.m., the surveyor observed ULP-B provide cares to R4. On November 5, 2024, at 11:43 a.m., regional director of nursing (RDN)-F stated they did not have current signed service plans for R3 or R4. On November 6, 2024, at 9:59 a.m., RDN-F stated they did not have a signed service plan for R2. On November 6, 2024, at 1:24 p.m., clinical nurse supervisor (CNS)-A stated the nurse who completed an assessment for the resident was responsible for creating and updating service plans. CNS-A stated service plans were required to be created at the time of admission, when	01640		

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01640	Continued From page 23 there is a change to the resident's needs, and yearly. CNS-A stated they were working for the licensee on an interim basis to assist the previous CNS, but then the CNS quit. CNS-A stated they were not working for the licensee when R2, R3, and R4 were admitted so they could not say why they were not updated with a signature. CNS-A stated they were currently trying to fix service plan issues. The licensee's Service Plan Guideline policy dated September 2023, indicated: "-The service plan and any revision must include a signature or other authentication by the home care provider and by the client or the client ' s representative documenting agreement on the services to be provided. -The service plan must be revised, if needed, based on the results of required client monitoring and/or reassessments." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
02110 SS=F	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and	02110		

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02110	Continued From page 24 design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure policies and procedures for assisted living with dementia care (ALFDC) were provided to residents and the residents' legal and designated representatives at the time of move in for three of three dementia care residents (R2, R3, R4). Further, the licensee failed to provide the required 10 dementia care policies. This practice resulted in a level two violation (a violation that did not harm a resident's health or	02110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35230	A. BUILDING: _____ B. WING _____	11/07/2024

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02110	Continued From page 25 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 was admitted to the licensee on March 1, 2024. R2 resided in the memory care unit. R3 R3 was admitted to the licensee on October 28, 2022, as an independent living resident. R3 began receiving services from the licensee on January 21, 2023. R4 R4 was admitted to the licensee on June 12, 2023. R4 resided in the memory care unit. R2, R3 and R4's records lacked evidence the licensee provided the resident, or residents' designated representative, with the required policies and procedures for the ALFDC license. The licensee lacked the 10 required dementia care policies in the following topics: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that	02110		

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02110	Continued From page 26 provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. On November 5, 2024, at 8:12 a.m., the surveyor observed unlicensed personnel (ULP)-B administer medications to R2. On November 5, 2024, at 8:35 a.m., the surveyor observed ULP-B provide cares to R4. On November 4, 2024, at 2:12 p.m., the surveyor emailed licensed assisted living director (LALD)-D requesting evidence the required dementia care policies were provided to residents or the resident's representative. On November 5, 2024, at 11:51 a.m., regional director of operations (RDO)-G provided a Special Care/Memory Support Community at [Licensee] form and stated it was included with their resident admission packet and included information about the required dementia care policies and their availability to the resident; the surveyor and RDO-G were unable to find the information on the form.	02110		

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02110	Continued From page 27 On November 6, 2024, at 9:00 a.m., the surveyor emailed LALD-D requesting the required dementia care policies and evidence they were provided to residents or resident representatives. On November 6, 2024, at 9:52 a.m., LALD-D provided two untitled documents included in their admission packet to the surveyor and stated they should address the required dementia policies. The documents lacked information addressing the required dementia care policies. On November 6, 2024, at 9:55 a.m., regional director of nursing (RDN)-F and LALD-D stated they could not find anything in their records about providing the required dementia care policies. The surveyor requested a copy of the 10 dementia care policies. On November 6, 2024, at 12:58 p.m., LALD-D stated RDN-F found the required dementia care policies; the surveyor requested a copy of the policies. On November 6, 2024, at 1:16 p.m., the surveyor emailed RDN-F, LALD-D, and CNS-A requesting the required dementia care policies and evidence they were provided to residents or resident representatives. On November 6, 2024, at 2:20 p.m., RDO-G provided the Special Care/Memory Support Community at [Licensee] form (which RDO-G had already provided to the surveyor on November 5, 2024, at 11:51 a.m.) and another untitled document and stated the required dementia care policies should be address in the forms. The surveyor explained they needed to provide the surveyor with the actual policies themselves and	02110		

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02110	Continued From page 28 evidence they were provided to the resident or the resident's representative. On November 6, 2024, at 3:05 p.m., the surveyor emailed RDN-F, LALD-D, and CNS-A with a final request for the required dementia care policies. On November 6, 2024, at 4:14 p.m., the surveyor received an email response to the email sent at 3:05 p.m., which did not include the required dementia care policies or evidence they were provided to the resident or the resident's representative. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02110		
02290 SS=F	144G.91 Subd. 2 Legislative intent The rights established under this section for the benefit of residents do not limit any other rights available under law. No facility may request or require that any resident waive any of these rights at any time for any reason, including as a condition of admission to the facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee limited the resident's right to choose when the licensee required residents to follow bed rail rules which restricted the resident's right to select their preferred bed rail for two of two residents utilizing consumer bed rails (R3, R6). This practice resulted in a level two violation (a	02290		

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02290	Continued From page 29 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: R3 R3 was admitted to the licensee on January 21, 2023, as an independent living resident. R3 began receiving assisted living services from the licensee on October 28, 2022. R3's Service Addendum to the Assisted Living Contract dated November 6, 2024, unsigned, indicated R3 received services for monitoring bed rails for safe use. R3's 90-day Nursing Assessment dated August 1, 2024, indicated R3 utilized a consumer bed rail. R6 R6 was admitted to the licensee on January 12, 2021. R6's 90-day Nursing Assessment dated October 21, 2024, indicated R6 utilized a consumer bed rail. The licensee's Important Information for Our Residents and Families form dated February 2022, indicated: "It is our general practice to not allow bed rails or other similar assistive devices i.e. transfer poles, grab bars. In the rare occasions that such device is determined to benefit the resident, the following criteria must be followed:	02290		

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02290	Continued From page 30 -Resident agrees not to use or apply bed rails or other assistive device of any type without first notifying facility and allowing facility to conduct an assessment to determine the risk/benefit of bed rail use. -The facility reserves the right to request further evaluation by physical/occupational therapist and/or a physician." On November 5, 2024, at 9:20 a.m., the surveyor observed R6's bed which had a Stander black arch style bar consumer bed rail attached firmly to the right side of R6's bed. R6 provided a letter to the surveyor given to them by the licensee's clinical nurse supervisor (CNS)-H who was no longer employed by the licensee. The letter was untitled and indicated there would only be two approved bed rail styles allowed to be used at the facility. It indicated, "We are asking for all bedrails not in compliance to be removed and replaced with the safer alternative we are suggesting. We have set a deadline of Monday, September 30th for all bedrails not in compliance to have been removed. If they have not been removed by this date, we will be required to remove them ourselves. Families will need to collect them from our clinical offices at that time." R6 stated CNS-H told them they had to get rid of their current bed rail but R6 wanted to keep it. R6 stated they felt like they were being forced to remove their bed rail and use one approved for use by the facility. R6 stated the licensee ordered a Halo bed rail and was being charged $119.00 by the licensee to pay for the new bed rail. R6 stated the licensee allowed them to keep their current bed rail until the new one arrived. R6 provided the above-mentioned untitled letter to the surveyor and stated they were told by CNS-H there were only two preapproved bed rails they were allowed to use and would be responsible for the cost of	02290		

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02290	Continued From page 31 the replacement bed rail. On November 5, 2024, at 9:43 a.m., the surveyor observed R3's bed which had a Home Bed Side Helper, Bedside Valet, consumer bed rail. It was cream in color, had three horizontal bars, four legs touching the ground and was attached firmly to right side of R3's bed frame. R3 stated CNS-H told them they could not have their current bed rail and would have to get one of the two approved bed rails and pay for it themselves. R3 stated they wanted to keep the bed rail they were currently using. On November 6, 2024, at 8:20 a.m., licensed assisted living director (LALD)-D stated they had worked for the organization before they started as the LALD yesterday, November 5, 2024. They stated they were not familiar with the letter given to R6 and would need to look into it and see if they could find any copies of the form. LALD-D stated they understood this was a resident rights issue. On November 6, 2024, at 12:58 p.m., LALD-D stated their Resident Assistive Devices policy was provided to residents when they were admitted. LALD-D stated they could not find a template or copy of the form provided to R6. LALD-D stated they would speak to R3 and R6 individually to address the bed rail issue. On November 6, 2024, at 2:20 p.m., regional director of operations (RDO)-G stated the Important Information for Our Residents and Families form was provided to residents and families at the time of admission. On November 6, 2024, at 2:30 p.m., regional director of nursing (RDN)-F stated the untitled	02290		

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02290	Continued From page 32 form used to inform R6 they would need to remove their bed rails and purchase a preapproved bed rail was not a form used by the organization; CNS-H must have composed it on their own and given it to R6. The licensee's Resident Assistive Devices policy revised in December 2022, indicated: "GUIDELINE It is the general practice of LSSL not to allow bed rails or other similar assistive devices i.e. transfer poles, grab bars. In the rare occasions that such a device is determined to benefit the resident, the following criteria must be followed: Resident and/or Responsible Party agrees not to use or apply bed rails or other assisted device of any type without first notifying facility and allowing facility to conduct an assessment to determine the risk: benefit of device use. The facility reserves the right to request further evaluation by a physical/occupational therapist and/or a physician. The following information is provided to the resident upon admission and/or prior to installation of the device and specifically bed rail/assist bars: Resident acknowledges bed rails are most often considered a restraint and may cause serious injury including fractures, asphyxiation, strangulation and death. In the event it is determined by facility staff that the device/rail(s) poses a greater risk for injury than benefit for Tenant's use, Resident agrees to not apply/utilize the device(s). In the event a bed rail may be determined to be a benefit to Resident, Resident will be responsible	02290		

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02290	Continued From page 33 for purchase of the bed rail(s) that is approved by the manufacturer for use with Resident's bed frame as not all bed rails are compatible with all bed types. Resident also acknowledges and agrees that portable bed rail(s) that do not attach to the bed frame are never allowed due to their inherent risk. Resident agrees to provide facility with a copy of the manufacturer guidelines for any consumer grade device. Resident also agrees that even if a bed rail is initially determined to be a benefit by Facility, if the bed rails are later determined to pose a greater risk for injury than benefit the bed rails will be removed." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02290		
02310 SS=G	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical or nursing standards for one of three residents (R4) who utilized hospital or consumer	02310		

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02310	Continued From page 34 bed rails. 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). This resulted in an immediate correction order on November 5, 2024. The findings include: R4 was admitted to the licensee on June 12, 2023. R4 resides in a memory care (MC) locked unit for resident safety. R4's diagnosis included dementia, congestive heart failure and hypertension. R4's Service Addendum to the Assisted Living Contract form dated November 21, 2023, indicated R4 received services for activities of daily living (ADLs), medication assistance and administration, bathing, toileting/incontinence assistance, escort assist and dressing. Additionally, it specifically indicated R4 was to receive safety checks for bed rails, "Community to provide monitoring of bed rails for safe use. R4's 90-Day Nursing Assessment dated September 11, 2024, indicated R4 did not have a bed rail or hospital bed. R4's Change of Condition Nursing Assessment dated October 18, 2024, indicated R4 did not have a bed rail or hospital bed.	02310		

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02310	Continued From page 35 R4's record lacked the following required components: - Measurements of entrapment zones; - Resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - Resident preferences; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements. On November 5, 2024, at 8:35 a.m., the surveyor observed R4's room which had a hospital bed with the headboard pushed up against one of the walls; the hospital bed had bilateral half bed rails. On November 5, 2024, at 11:23 a.m., regional director of nursing (RDN)-F stated bed rail assessments were completed in Eldermark (charting software). On November 5, 2024, at 11:40 a.m., the surveyor inspected R4's hospital bed rails by wiggling and pulling on them; both were firmly attached to the hospital bed. On November 5, 2024, at 11:54 a.m., clinical nurse supervisor (CNS)-A stated both of R4's assessments indicated R4 did not have a bed rail. On November 5, 2024, at 1:17 p.m., RDN-F stated R4's last assessment was completed on October 18, 2024, after returning from the hospital and the hospital bed and bed rails were not in R4's room. RDF-D stated it must have been delivered after R4's return to the facility on	02310		

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02310	Continued From page 36 October 18, 2024. RDF-D and licensed assisted living director (LALD)-D stated they contacted the company who provided the hospital bed and bed rails today to find out when it was delivered. On November 5, 2024, at 1:21 p.m., CNS-A stated they were aware of the hospital bed in R4's room. CNS-A stated they were present for R4's assessment on October 18, 2024, conducted in R4's room and the hospital bed was there during the assessment; the bed rails were on the hospital bed during the assessment. CNS-A stated they did not assess the hospital bed rails. CNS-A stated another nurse completed the assessment while they were in the room. CNS-A stated they did not assess R4's bed rails. CNS-A stated they were working for the licensee on an interim contract and there had been a lot of nurse turnover prior to their arrival which made it challenging to make sure everything was completed and up to date. "CNS-A stated they were aware of the assessment requirements. CNS-A stated they were unsure how frequently a bed rail assessment was required to be completed. CNS-A stated all staff were trained to report new bed rails to the nurse The Food and Drug Administration's (FDA), A Guide to Bed Safety, dated 2000, and revised April 2010, indicated following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to	02310		

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02310	Continued From page 37 determine how best to keep the patient safe." The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) dated October 15, 2024, indicated, " To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint. Additionally, the licensee must ensure the bed rail measurements are documented and that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendations." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Measurements - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". The licensee's Resident Assistive Devices policy, last revised in December 2022, indicated: "Facility clinical staff will be responsible for completing the	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35230	A. BUILDING: _____ B. WING _____	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
URBANA PLACE SENIOR LIVING	5601 94TH AVENUE NORTH BROOKLYN PARK, MN 55443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 38 appropriate assessments and reviewing the risk benefits of such devices with residents and responsible parties. Any device utilized by a resident shall have a monthly Safety Check schedule to a facility nurse." Additionally it indicated assessments were to include: "For Hospital Style Beds and Devices: o Purpose and intention of the bed rail o Measurements -The body part dimensions used to develop FDA's dimensional limit recommendations are summarized in Table below. Key Body Part Dimension LIMITS Head 120 mm (4 ¾ inches) Neck 60 mm (2 3/8 inches) and an angle > 60 degree Chest 318 mm (12 ½ inches) SOURCE: https://www.fda.gov/media/71460/download o The resident's bed rail use/need assessment o Risk vs. benefits discussion (individualized to each resident's risks) o The resident's preferences o Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation 3 o Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements (WI only)" No further information provided. TIME PERIOD FOR CORRECTION: Immediate	02310		

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

Type: Full
Date: *11/04/24*
Time: 08:25:41
Report: 1018241197

Food and Beverage Establishment Inspection Report

Location:
Urbana Place Senior Living
5601 94th Avenue North
Brooklyn Park, MN55443
Hennepin County, 27

Establishment Info:
ID #: 0038141
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7634029190
ID #:

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

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

SMARTPOWER: = 272PPM at Degrees Fahrenheit
Location: 3 COMP SINK
Violation Issued: No

Hot Water: = at 165 Degrees Fahrenheit
Location: DISHWASHER
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding/ DELI MEAT
Temperature: 39 Degrees Fahrenheit - Location: PREP COOLER
Violation Issued: No

Process/Item: Cold Holding/ EGGS
Temperature: 38 Degrees Fahrenheit - Location: PREP COOLER
Violation Issued: No

Process/Item: Cold Holding/ TOMATO
Temperature: 39 Degrees Fahrenheit - Location: PREP COOLER
Violation Issued: No

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

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

Type: Full
Date: *11/04/24*
Time: 08:25:41
Report: 1018241197
Urbana Place Senior Living

Food and Beverage Establishment Inspection Report

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

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

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

VIEWED EMPLOYEE ILLNESS LOG AND DISCUSSED ILLNESS POLICY.

NO COOLING OF PREVIOUSLY COOKED FOODS. ONLY FOODS SAVED ARE FRUITS AND DESSERTS. ONLY SAVED FOR 2 DAYS.

ESTABLISHMENT USES ALL PASTEURIZED EGGS.

NO ORDERS ISSUED.

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1018241197 of 11/04/24.

Certified Food Protection Manager: JODIE M MILLER

Certification Number: FM29834 Expires: 06/16/26

Inspection report reviewed with person in charge and emailed.

Signed: _____
ZEUS SPENCER
DIRECTOR OF DINING SERVICES

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