Electronically Delivered

April 13, 2023

Licensee
Arbor Lakes Senior Living, LLC
12001 80th Avenue North
Maple Grove, MN 55369

RE: Project Number(s) SL30754015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on March 2, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.

- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

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

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

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

Please address your cover letter for reconsideration requests to:

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

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

Sincerely,

Jonathan Hill, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-3993 Fax: 651-281-9796

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30754 | A. BUILDING: _____ B. WING _____ | 03/02/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARBOR LAKES SENIOR LIVING LLC | 12001 80TH AVENUE NORTH MAPLE GROVE, MN 55369 |

| (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 |
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| 0 000 | Initial Comments<br><br>******ATTENTION******<br><br>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.<br><br>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.<br><br>INITIAL COMMENTS:<br>SL30754015-0<br><br>On February 27, 2023, through March 2, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 173 active residents: 86 receiving services under the Assisted Living with Dementia Care license. | 0 000 | Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living with Dementia Care licensed 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 evaluators ' findings is the Time Period for Correction.<br><br>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.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3. | |
| 0 480 SS=F | 144G.41 Subd 1 (13) (i) (B) Minimum requirements | 0 480 | | |

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| 0 480 | Continued From page 1<br><br>(13) offer to provide or make available at least the following services to residents:<br>(B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code.<br>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).<br>The findings include:<br>Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated February 27, 2023, for the specific Minnesota Food Code deficiencies.<br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 480 | | |
| 0 485 SS=C | 144G.41 Subd 1. (13) (i) (A) and (C) Minimum Requirements<br><br>(13) offer to provide or make available at least the following services to residents:<br>(i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and | 0 485 | | |

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| 0 485 | Continued From page 2<br><br>fresh vegetables. The following apply:<br>(A) menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; and<br>(C) the facility cannot require a resident to include and pay for meals in their contract;<br>(ii) weekly housekeeping;<br>(iii) weekly laundry service;<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to have a menu prepared at least one week in advance and made available to all residents. This had the potential to affect all residents of the licensee.<br><br>This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>On February 27, 2023, at 10:55 a.m., the evaluator observed the menu plan posted on the refrigerator in the memory care kitchens was for one week running from Monday, February 27, 2023, through Sunday, March 5, 2023.<br><br>On February 28, 2023, at 7:05 a.m., licensed assisted living director (LALD)-A stated the | 0 485 | | |

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| 0 485 | Continued From page 3<br>menus was prepared and posted on the website. When asked if the menus were distributed to the residents at least one week in advance LALD-A stated the menu was distributed to the residents, he further stated the weekly menu can be found in each kitchen for the current week.<br><br>The licensee's food service and menu planning policy dated August 1, 2021, indicated menus would be prepared at least one week in advance and made available to all residents.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 485 | | |
| 0 510 SS=D | 144G.41 Subd. 3 Infection control program<br><br>(a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control.<br>(b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities.<br>(c) The facility must maintain written evidence of compliance with this subdivision.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program to comply with accepted health care, medical and nursing | 0 510 | | |

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| 0 510 | Continued From page 4<br>standards for infection control for one of one employee (unlicensed personnel (ULP)-D) observed to perform blood glucose testing and insulin administration.<br><br>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).<br><br>The findings include:<br><br>On February 28, 2023, at 7:40 a.m., the evaluator observed ULP-D prepare to check R7's blood glucose and administer insulin. ULP-D gathered the supplies out of the kitchen cupboard and walked to R7's living room where R7 was seated in her recliner.<br>- Without performing hand hygiene, ULP-D donned gloves, cleansed R7's finger with an alcohol pad, used a lancet to poke the finger, and placed a drop of blood onto the testing strip in the device.<br>- Without removing the soiled gloves or performing hand hygiene, ULP-D cleansed R7's abdominal area with an alcohol prep pad, administered 22 units (U) of Lantus insulin SQ (subcutaneously-into the fat just under the skin) into abdominal area, placed Lantus insulin cap on, put Lantus insulin back in the cupboard, and handed R7 the medication cup with oral medications, R7 took the medications with water.<br>- ULP-D removed the gloves, and without performing hand hygiene, ULP-D donned a fresh pair of gloves, obtained a washcloth from the | 0 510 | | |

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| 0 510 | Continued From page 5 | 0 510 | | |

bathroom, wiped down R7's face, put the washcloth back in the bathroom.
- Without removing gloves and performing hand hygiene, ULP-D exited R7's room, went to the kitchen and prepared R7's breakfast, set-up up the breakfast, and then removed the soiled gloves and performed hand hygiene.

When interviewed on February 28, 2023, at 8:00 a.m., ULP-D stated they usually performed hand hygiene before and after cares.

On February 28, 2023, at 2:00 p.m., director of nursing (RN)-B stated direct care staff had been trained on infection control and when hand hygiene should be performed. RN-B further stated the ULPs will be retrained to remind them infection control procedure.

The Center for Disease Control and Prevention (CDC) document titlted Hand Hygiene in Healthcare Settings dated January 8, 2021, indicated the following are the clinical indications for hand hygiene:
- When hands are visibly soiled;
- After caring for a person with known or suspected infectious diarrhea;
- After known or suspected exposure to spores (B. anthracis, C difficile outbreaks);
- Immediately before touching a patient;
- Before moving from work on a soiled body site to a clean body site on the same patient;
- After touching a patient or the patient ' s immediate environment;
- After contact with blood, body fluids or contaminated surfaces; and
- Immediately after glove removal.

The licensee's Handwashing policy dated August

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| 0 510 | Continued From page 6<br>1, 2021, directed handwashing would be performed by all employees, as necessary, between tasks and procedures, and after bathroom use, to prevent cross-contamination.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 510 | | |
| 0 550 SS=F | 144G.41 Subd. 7 Resident grievances; reporting maltreatment<br><br>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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to post in a conspicuous place information about the facility's grievance procedure. This had the potential to affect the licensee's current residents, staff, and visitors. | 0 550 | | |

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| 0 550 | Continued From page 7<br><br>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).<br><br>The findings include:<br><br>The licensee lacked posting in a conspicuous place, the grievance procedure to include any information for reporting suspected maltreatment to Minnesota Adult Abuse Reporting Center (MAARC).<br><br>On February 27, 2023, at 11:15 a.m., during the facility tour, the evaluator observed the grievance procedure on a bulletin board around the corner of the front entrance, hanging on the wall behind the pub area.<br><br>On February 27, 2023, at 11:30 a.m., licensed assisted living director (LALD)-A stated the grievance procedure posted was hidden from the residents view and many people may not know where to find it. The LALD-A further stated licensee will post the required notice with content noted above in a conspicuous place.<br><br>The licensee's Compliant/Grievance Posting policy dated August 2021, indicated licensee will post in a conspicuous place, information about their compliant/grievance procedure.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One | 0 550 | | |

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| 0 550 | Continued From page 8<br>(21) days | 0 550 | | |
| 0 570 SS=C | 144G.42 Subdivision 1 Display of license<br><br>The original current license must be displayed at the main entrance of each assisted living facility. The facility must provide a copy of the license to any person who requests it.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to display the original current license at the main entrance of the assisted living facility as required. This had the potential to affect all the licensee's 173 current residents, staff, and visitors.<br><br>This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents).<br><br>The findings include:<br><br>During a facility tour on February 27, 2023, at 11:15 a.m., the evaluator observed no posting of the original current license at the facility main public entrance. Licensee's original, current license was posted on the first floor, inside the nursing office.<br><br>On February 27, 2023, at 11:30 a.m. licensed assisted living director (LALD)-A stated licensee was not aware of the requirement to post the | 0 570 | | |

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| 0 570 | Continued From page 9<br><br>licensee in public view location. LALD-A also stated licensee will post the licensee in the main entrance area where it can be easily seen by everyone.<br><br>The licensee's Assisted Living License and Postings policy dated August 1, 2021, indicated licensee would maintain a current Assisted Living License issued by the Minnesota Department of Health, and the issued license would be posted at the main entrance of the facility.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 570 | | |
| 0 640 SS=F | 144G.42 Subd. 7 Posting information for reporting suspected c<br><br>The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by:<br>(1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility;<br>(2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and<br>(3) providing reasonable accommodations with information and notices in plain language.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to support protection and safety through access to the state's systems | 0 640 | | |

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| 0 640 | Continued From page 10<br>for reporting suspected criminal activity and suspected vulnerable adult maltreatment as required. This had the potential to affect all the licensee's current residents, staff, and visitors.<br><br>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).<br><br>The findings include:<br><br>The licensee failed to:<br>- post the 911 emergency number in common areas and near telephones provided by the assisted living facility.<br><br>On February 27, 2023, at 11:15 a.m., during a tour of the facility's entrance, front desk area, common area, and near telephones on the first floor, the evaluator noted no 911 information posted.<br><br>On February 27, 2023, at 11:30 a.m., licensed assisted living director (LALD)-A stated licensee was not awre of the requirement. LALD-A further stated licensee will post all required information immediately.<br><br>The licensee's Emergency/911 policy dated August 2021, indicated licensee would call 911 to summon assistance and aid when handling emergency situations. Licensee's policy failed to include where 911 emergency numbers would be | 0 640 | | |

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| 0 640 | Continued From page 11<br>posted.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 640 | | |
| 0 680 SS=F | 144G.42 Subd. 10 Disaster planning and emergency preparedness<br><br>(a) The facility must meet the following requirements:<br>(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;<br>(2) post an emergency disaster plan prominently;<br>(3) provide building emergency exit diagrams to all residents;<br>(4) post emergency exit diagrams on each floor; and<br>(5) have a written policy and procedure regarding missing residents.<br>(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.<br>(c) The facility must meet any additional requirements adopted in rule.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the | 0 680 | | |

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| | 30754 | A. BUILDING: _____ B. WING _____ | 03/02/2023 |

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| 0 680 | Continued From page 12<br><br>licensee failed to maintain a written emergency preparedness (EP) plan with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff, and visitors.<br><br>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).<br><br>The findings include:<br><br>The licensee's undated EP plan lacked the following content:<br>- EP Program Patient Population;<br>- Subsistence Needs for Staff and Patients;<br>- Policies and Procedures for Medical Documents;<br>- Policies and Procedures for Volunteers;<br>- Roles under a Waiver Declared by Secretary;<br>- Methods for Sharing Information;<br>- Sharing Information on Occupancy/Needs;<br>- Emergency Prep Training and Testing;<br>- Emergency Prep Training Program; and<br>- Emergency Prep Testing Requirements;<br><br>On February 28, 2023, at 1:35 p.m., licensed assisted living director (LALD)-A stated the EP plan was missing required information. Additionally, LALD-A stated the licensee was aware of the EP requirement and would update the EP to reflect the requirement.<br><br>The licensee's Emergency Preparedness policy dated August 1, 2021, indicated, "[licensee] will | 0 680 | | |

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| 0 680 | Continued From page 13<br>have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services."<br><br>No additional information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 680 | | |
| 0 810 SS=F | 144G.45 Subd. 2 (b)-(f) Fire protection and physical environment<br><br>(b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:<br>(1) location and number of resident sleeping rooms;<br>(2) employee actions to be taken in the event of a fire or similar emergency;<br>(3) fire protection procedures necessary for residents; and<br>(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.<br>(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.<br>(d) Fire safety and evacuation plans shall be readily available at all times within the facility.<br>(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. | 0 810 | | |

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| 0 810 | Continued From page 14<br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on a record review and interview, the licensee failed to develop a fire safety and evacuation plan with required elements and failed to provide required employee and resident training on fire safety and evacuation. This had the potential to affect all staff, residents, and visitors.<br><br>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).<br><br>Findings include:<br><br>A record review and interview were conducted on March 2, 2023, at approximately 10:15 a.m. of documents provided by licensed assisted living director (LALD)-A, regional director of operations (RDO)-G and director of maintenance (DM)-H on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility.<br><br>Record review of the available documentation | 0 810 | | |

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| 0 810 | Continued From page 15<br>indicated that the licensee did not maintain the fire safety and evacuation plan for the facility as follows:<br>Record review of available documentation indicated the fire evacuation floor plan did not contain resident room number.<br><br>Record review of the available documentation indicated that the licensee did not provide employee actions to be taken, in detail for this specific facility in the event of a fire or similar emergency.<br><br>Record review of the available documentation indicated that the licensee did not have fire protection procedures necessary for residents in the event of a fire or similar emergency included in the plan.<br><br>Record review of the available documentation indicated that the fire safety and evacuation plan did not include procedures for employees in regard to resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation.<br><br>Record review of the available documentation indicated that employees did not receive training upon initial hire and twice per year thereafter on the facility fire safety and evacuation plan.<br><br>Record review of the available documentation indicated that the licensee did not provide training to residents who are capable of self-evacuation on the proper actions to be taken in the event of a fire in regard to movement, evacuation, and relocation.<br><br>All deficiencies were verified by LALD-A, RDO-G | 0 810 | | |

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| 0 810 | Continued From page 16<br>and DM-H during the interview at approximately 11:00 a.m.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 0 810 | | |
| 0 910 SS=C | 144G.50 Subd. 2 (a-b) Contract information<br><br>(a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility.<br>(b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of:<br>(1) the facility and contracted service provider when applicable;<br>(2) the licensee of the facility;<br>(3) the managing agent of the facility, if applicable; and<br>(4) the authorized agent for the facility.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to execute a written contract with the required content for two of two residents (R3, R6). This had the potential to affect all residents living in the assisted living facility.<br><br>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). | 0 910 | | |

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| 0 910 | Continued From page 17<br>The findings include:<br><br>R3's record included a signed Assisted Living Contract dated August 15, 2022.<br><br>R6's record included a signed Assisted Living Contract dated August 7, 2021.<br><br>R3 and R6's Assisted Living Contracts lacked the Health Facility Identification (HFID) number of the facility in a conspicuous place and manner on the contract.<br><br>On February 27, 2023, at 12:35 p.m., licensed assisted living director (LALD)-A stated licensee was aware of the contract language, and confirmed they were working with their attorneys to update contract to meet the statute expectations.<br><br>Licensee's Signing an Assisted Living Contract dated August 1, 2021, indicated licensee would provide the prospective resident and/or responsible person a copy of the appropriate assisted living contract.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 0 910 | | |
| 0 950 SS=C | 144G.50 Subd. 3 Designation of representative<br><br>(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: | 0 950 | | |

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| 0 950 | Continued From page 18<br><br>"RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES.<br><br>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."<br><br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ask the resident the to identify a designated representative in writing for three of three residents (R2, R3, R6).<br><br>This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). | 0 950 | | |

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| 0 950 | Continued From page 19<br><br>The findings include:<br><br>R2<br>R2 admitted to licensee November 12, 2023, and started receiving assisted living services.<br><br>R2's Assisted Living Contract dated November 12, 2023, included a page to name R2's designated representative or decline by checking a box and initial. R2's designated representative page was left blank, even though R2 and the provider representative signed the contract to acknowledge R2 had read through the agreement.<br><br>R3<br>R3 admitted to licensee July 18, 2015, under the former comprehensive license and started receiving assisted living services August 1, 2021.<br><br>R3's Assisted Living Contract dated August 15, 2022, included a page to name R3's designated representative or decline by checking a box and initial. R3's designated representative page was left blank, even though R3 and the provider representative signed the contract to acknowledge R3 had read through the agreement.<br><br>R6<br>R6 admitted to licensee August 1, 2021.<br><br>R6's Assisted Living Contract dated August 7, 2021, included a page to name R6's designated representative or decline by checking a box and initial. R6's designated representative page was left blank, even though R6 and the provider representative signed the contract to acknowledge R6 had read through the | 0 950 | | |

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| 0 950 | Continued From page 20<br>agreement.<br><br>On February 28, 2023, at 2:19 p.m., licensed assisted living director (LALD)-A confirmed R2, R3, and R6's designated representative forms were not filled out by identifying a designated representative or, indicating R2, R3, or R6 declined to list a representative. LALD-A also stated licensee was aware of this requirement but these were emission errors when completing the contract, to which LALD-A further stated licensee will more careful to fully fill out the contract with resident before signing.<br><br>The licensee's Designated Representative policy, dated August 1, 2021, indicated the licensee would offer resident's the opportunity to identify a designated representative in writing, and a signed Designated Representative form would be filled out documenting the resident's choice in designated representative, and the form would be kept in the resident record.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 0 950 | | |
| 0 970 SS=F | 144G.50 Subd. 5 Waivers of liability prohibited<br><br>The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. | 0 970 | | |

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| 0 970 | Continued From page 21<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal property of a resident. This had the potential to affect all residents living at the facility.<br><br>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).<br><br>The findings include:<br><br>On February 27, 2023, at 10:10 a.m., during the entrance conference, the licensee provided a survey binder that included the licensee's current Assisted Living Contract.<br><br>The licensee's Assisted Living Contract, included the following language indicating a waiver of liability in various sections:<br>Page 14, section 18 "Personal Property":<br>"Resident agrees that Provider is not responsible for any loss or damage to Resident's personal property due to any reason or cause, including theft, other than Provider's own negligence. Resident further agrees that Provider is not responsible for damage to Resident's personal property due to fire, water, tornado or other acts of nature and events beyond Provider's control."<br><br>Page 17, section 23 "Indemnification" | 0 970 | | |

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| 0 970 | Continued From page 22<br><br>"As an occupant of the Community, Resident assumes the risk for Resident's own safety and for the safety of Resident's guests and agents. Resident will indemnify and hold harmless Provider, its employees, officers, managers, owners and agents from and against any and all claims, actions, damages, and liability and expense in connection with loss of life, personal injury or damage to property, arising from or out of, or caused wholly or in part by, an act or omission of Resident or Resident's guests or agents."<br><br>Page 17, section 25 "Liability"<br>Provider is not liable to Resident or Resident's guests for any injury, death or property damage occurring in the Apartment or on Provider's premises unless such injury, death or property damage occurs as the result of Provider's own negligent acts or omissions, or those of its employees, officers, managers, owners, or agents. Provider is also not liable for any injury, death or damage occurring as the result of Resident's receipt of health-related, supportive, or other services from third-party providers. Unless caused by one of the aforementioned excepted reasons, Resident agrees to hold Provider harmless from any and all claims for injuries, property damage or any other loss resulting from an accident or other occurrence in the Apartment or on Provider's premises.<br><br>On February 28, 2023, at 2:19 p.m., licensed assisted living director (LALD)-A stated licensee was aware of the liability clauses in the contract and was working with their attorneys to update contract to meet the statute expectations.<br><br>No further information was provided. | 0 970 | | |

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| 0 970 | Continued From page 23<br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 970 | | |
| 01060 SS=F | 144G.52 Subd. 9 Emergency relocation<br><br>(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.<br>(b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum:<br>(1) the reason for the relocation;<br>(2) the name and contact information for the location to which the resident has been relocated and any new service provider;<br>(3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities;<br>(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<br>(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.<br>(c) The notice required under paragraph (b) must be delivered as soon as practicable to:<br>(1) the resident, legal representative, and designated representative;<br>(2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case | 01060 | | |

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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 |
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| 01060 | Continued From page 24<br>manager; and<br>(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.<br>(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<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation to the resident, legal representative, or designated representative, and failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) of the emergency relocation greater than four days, for two of two residents (R15, R16).<br><br>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).<br><br>The findings include:<br><br>R15 was admitted to licensee November 17, 2020, under the comprehensive licensure and started receiving assisted living services on August 01, 2021.<br><br>R15's progress note dated February 3, 2023, at 11:01 a.m. indicated R15 was sent out to the hospital that morning. Note stated resident was | 01060 | | |

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| 01060 | Continued From page 25 | 01060 | | |

short of breath and O2 saturation was at 65% on room air. ULP reached out to the nurse on call, RN directed ULP to send the resident to the hospital. Resident was admitted and put on LOA from facility. R15 was relocated from the facility for 24 days from February 3, 2023, through February 28, 2023.

R15's unsigned service plan printed February 28, 2023, indicated R15 received services to include registered nurse (RN) comprehensive assessment, monitoring and reassessment, medication set up, daily weights, escorts, laundry assistance, toileting, dressing, bathing, personal hygiene, grooming, transfers, and medication administration.

R15's record lacked evidence the licensee provided the resident or resident's representative a written emergency relocation notice and failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) of the emergency relocation greater than four days as required.

R16 was admitted to licensee July 28, 2019, under the comprehensive licensure and started receiving assisted living services on August 01, 2021.

R16's progress note dated February 16, 2023, indicated R16 pressed her pendant for assistance and ULP found the resident laying on the floor in the closet. Resident was calling out in pain stating she thought she broke her back. ULP tried adjusting resident but could not reach her. RN directed ULP to call 911. RN called resident's daughter who wanted resident to be transferred to the hospital. R16 was relocated from the facility for 12 days from February 16, 2023,

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| 01060 | Continued From page 26<br>through February 28, 2023. Resident was being moved to a TCU on February 28, 2023 and still not returned to facility at the conclusion of the survey.<br><br>R16's unsigned service plan printed February 28, 2023, indicated R16 received services to include: RN comprehensive assessment, monitoring and reassessment, medication set up, monthly vitals, assistance with a.m. and p.m. cares, and medication administration.<br><br>R16's record lacked evidence the licensee provided the resident or resident's representative a written emergency relocation notice and failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) of the emergency relocation greater than four days as required.<br><br>On February 28, 2023, at 12:15 p.m., RN-B stated the licensee had not provided to the resident, resident's representative or to the ombudsman's office the required notices for emergency relocation as the facility just recently learned of the requirement. RN-B further provided an email dated February 13, 2023, from LALD-A changing the policy of the facility to complete emergency relocation notices per Minnesota Statue, therefore none of the licensee's residents with emergency relocation would have the notification at this time.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01060 | | |

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| 01620 | Continued From page 27 | 01620 | | |
| 01620 SS=D | 144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring<br><br>(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.<br>(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.<br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident assessment monitoring no more than 14 days after start of services and reassessments, not to exceed 90 calendar days from the last date of the assessment, for one of five residents (R2).<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or | 01620 | | |

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| 01620 | Continued From page 28<br>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).<br><br>The findings include:<br><br>R2 was admitted to the licensee on November 12, 2022.<br><br>R2's record included a RN evaluation/face-to-face, dated November 14, 2022, to serve as the initial assessment which exceeded the admission date by 2 calendar days. Another RN evaluation/face to face dated December 29, 2022, to be used as the 14 day assessment exceeded 14 calendar days from the start of services by 33 days.<br><br>On February 28, 2023, at 11:10 a.m., RN-B stated R2's admission assessment and 14-day assessment were done late. RN-B stated the assessments were not done timely and she did not have a reason for it or know why both assessments were late.<br><br>The licensee's policy 6.01 Assessment, reviews & monitoring dated August 1, 2021, indicated Southview Senior Communities (company managing the facility) would conduct a nursing assessment by a RN 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 executed a contract with a facility or the date on which a prospective resident moved in, whichever was earlier. The procedure of the assessment was laid out in the policy directing: | 01620 | | |

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| 01620 | Continued From page 29<br>1. The initial assessment or reassessment must include all of the elements of the uniform assessment tool as required, conducted in person (or telecommunications if distance is an issue), be in writing, dated and signed by the nurse who conducted the assessment.<br>3. Resident reassessment and monitoring must be conducted no more than 14 calendar days after the initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes on the needs of the resident and could not exceed 90 calendar days from the last date of the reassessment.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01620 | | |
| 01650 SS=F | 144G.70 Subd. 4 (f) Service plan, implementation and revisions to<br><br>(f) The service plan must include:<br>(1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences;<br>(2) the identification of staff or categories of staff who will provide the services;<br>(3) the schedule and methods of monitoring assessments of the resident;<br>(4) the schedule and methods of monitoring staff providing services; and<br>(5) a contingency plan that includes:<br>(i) the action to be taken if the scheduled service cannot be provided;<br>(ii) information and a method to contact the facility;<br>(iii) the names and contact information of persons | 01650 | | |

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| 01650 | Continued From page 30 | 01650 | | |

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

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to ensure the service plan included all required content for four of four residents (R2, R3, R4, R5).This had the potential to affect 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), 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' service plan signed on January 30, 2023, indicated R2 received assistance with safety checks, toileting, medication assistance, escorts, AM and PM cares, showers, monthly vitals, laundry, RN support with assessments and monitoring, medication set up and ordering medication.

R3

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| 01650 | Continued From page 31<br><br>R3's service plan signed on January 30, 2023, indicated R3 received assistance with AM cares using hoyer transfer, catheter cares, medication set up, 90-day reassessment, medication administration, blood glucose check, turn and reposition and toileting.<br><br>R4<br>R4' service plan signed on February 1, 2023, indicated R4 received assistance with medication set-up, medication administration, monthly vitals, blood sugar monitoring, and RN support with assessments and monitoring.<br><br>R5<br>R5' service plan revised on January 1, 2022, indicated R5 received assistance with PM cares, medication set-up, medication administration, toileting, escorts, daily weights, monthly vital signs, and RN support with assessments and monitoring.<br><br>R2 and R3's service plan lacked the following required content:<br>- the schedule of monitoring assessments of the resident;<br>- the schedule and methods of monitoring staff providing services.<br><br>R2, R3, R4, R5's service plan lacked the following required content:<br>- a contingency plan that includes:<br>- the action to be taken if the scheduled service could not be provided;<br>- the names and contact information of persons the resident wished to have notified in an emergency or if there was a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; | 01650 | | |

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| 01650 | Continued From page 32<br>and<br>- the circumstances in which emergency medical services were not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters.<br><br>On February 28, 2023, at 2:15 p.m., registered nurse (RN)-B verified R2, R3, R4 and R5's service plans were missing required content and the same service plan template was used for all licensee residents.<br><br>The licensee's Service Plans policy dated August 1, 2021, indicated all residents receiving assisted living services would have a service plan in place. Service plans were based on the outcomes of initial and subsequent assessments, reassessments, monitoring, and individual reviews of the resident's needs and preferences. The policy also included all the identified missing content.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01650 | | |
| 01730 SS=F | 144G.71 Subd. 5 Individualized medication management plan<br><br>(a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: | 01730 | | |

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| 01730 | Continued From page 33<br>(1) a statement describing the medication management services that will be provided;<br>(2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions;<br>(3) documentation of specific resident instructions relating to the administration of medications;<br>(4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis;<br>(5) identification of medication management tasks that may be delegated to unlicensed personnel;<br>(6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and<br>(7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions.<br>(b) The medication management record must be current and updated when there are any changes.<br>(c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to develop and maintain a current individualized medication management record (IMMP) for each resident to include all required content for two of two residents (R2, R3). | 01730 | | |

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| 01730 | Continued From page 34<br><br>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).<br><br>The findings include:<br><br>R2<br>R2's service plan signed on January 30, 2023, indicated R2 received assistance with safety checks, toileting, medication assistance, escorts, AM and PM cares, showers, monthly vitals, laundry, RN support with assessments and monitoring, medication set up and ordering medication.<br><br>R3<br>R3's service plan signed on January 30, 2023, indicated R3 received assistance with AM cares using hoyer transfer, catheter cares, medication set up, 90-day reassessment, medication administration, blood glucose check, turn and reposition and toileting.<br><br>R3's physician order sheet dated February 8, 2023, indicated R3 was ordered to receives to include: Atenolol 25 milligram (mg) one tablet every day, baclofen 20 mg two tablets three times daily, losartan 25 mg one tablet daily, calcium citrate with vitamin D one tablet daily, and vitamin C 500 mg two times daily.<br><br>R2 and R3's record lacked individualized medication management record with required content to include:<br>- identification of the medication management | 01730 | | |

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| 01730 | Continued From page 35 | 01730 | | |

services to be provided;
- a description of how medications would be stored, based on the resident's needs, risk of diversion and consistent with manufacturer's directions;
- identification of any specific instructions regarding the medications administered;
- identification of the person responsible for monitoring medication supplies and ordering refills on a timely basis;
- identification of team members responsible for medication management tasks, including tasks delegate to unlicensed staff;
- the procedure for notifying the RN when there was a problem with any medication management service; and
- any resident specific requirements relating to documentation of medication administration, verification that all medications were administered as prescribed and monitoring of medication use to avoid possible complications or adverse reactions.

On February 28, 2023, at 12:18 p.m., registered nurse (RN)-B stated the medication management plan was located in the service plan which also licensee referred to as plan of care.

The licensee's Medication Management Individualized Plan policy dated August 1, 2021, indicated for each resident at Southview Senior Communities (management company) medication management services, the facility would prepare and include in the service plan a written statement of the medication management services that would be provided to the resident. The policy also included the required content of IMMP.

No further information was provided

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| 01730 | Continued From page 36<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01730 | | |
| 01880 SS=F | 144G.71 Subd. 19 Storage of medications<br><br>An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to store prescription medication securely and permit only authorized personnel to have access for five of five residents (R8, R9, R10, R11, R12).<br><br>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).<br><br>The findings include:<br><br>On February 28, 2023, at 7:35a.m., the surveyor observed in the eastern memory care unit the following prescription and/or over the counter medications on R10's bathroom counter:<br>- unlabeled gold bond powder<br>- ammonium lactate cream<br>- unlabeled barrier cream<br>- unlabeled silicone cream | 01880 | | |

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|---|---|---|---|---|
| 01880 | Continued From page 37<br>- unlabeled Biotin mouth wash<br><br>On February 28, 2023, at 8:00 a.m., the surveyor observed in the eastern memory care unit the following prescription medications on R11's side table in the living room:<br>- Albuterol inhaler<br>-Albuterol nebulizer liquid<br><br>On February 28, 2023, at 8:15 a.m., the surveyor observed in the eastern memory care unit the following prescription and/or over the counter medications on R8 and R9's kitchen counter:<br>- unlabeled Robitussin cough syrup<br>- unlabeled hemp drops<br>- unlabelled magnesium gluconate<br>- unlabeled ear wax removal drops<br><br>On February 28, 2023, at 8:35a.m., the surveyor observed in the western memory care unit the following prescription and/or over the counter medications on R12's bedside table and bathroom counter:<br>- aquaphor healing ointment<br>- voltaren arthritis pain<br>- calmoseptine ointment cal<br>- nystop topical powder usp<br><br>On February 28, 2023, at 8:35 a.m., unlicensed personnel (ULP)-F stated the medications were placed on the bedside table and bathroom counter, for easy access to medications as they were used frequently.<br><br>On February 28, 2023, at 8:40 a.m., unlicensed personnel (ULP)-E stated the medications were placed on the bathroom counter,kitchen counter and side tables for easy access to medications as they were used frequently. | 01880 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30754 | A. BUILDING: _____ B. WING _____ | 03/02/2023 |

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| 01880 | Continued From page 38<br><br>On February 28, 2023, at 11:04 a.m., registered nurse (RN)-B stated all medications were supposed to be securely locked and stored per manufacturer's directions. RN-B also stated sometimes family would bring medications into the resident rooms without informing licensee nurse.<br><br>Licensee Medication Storage policy dated August 1, 2021, indicated when medications were managed and stored by Southview Senior Communities (management company), medications would be kept securely locked and stored per manufacturer's directions. Only authorized staff would have access to stored medications.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01880 | | |
| 01890 SS=F | 144G.71 Subd. 20 Prescription drugs<br><br>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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to ensure medications were maintained bearing the original prescription label with legible information for two of two residents (R12, R13) and failed to discard expired | 01890 | | |

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|---|---|---|---|---|
| 01890 | Continued From page 39 | 01890 | | |

medication for three of four residents (R12, R13, R14).

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:

PRESCRIPTION LABEL
On February 28, 2023, at 7:10 a.m., the surveyor observed the memory care unit medication cabinets for R12 and R13 and observed the following unlabeled medications:
- R12 imodium
- R13 acetaminophen 500 milligram (mg)

EXPIRED MEDICATIONS
On February 28, 2023, at 7:20 a.m., the surveyor observed the memory care unit medication cabinets for R12, R13, and R14 and observed the following expired medications:
R12
- nystop topical powder USP expired July 21, 2021; and
- two bottles of nystatin topical powder expired September 8, 2022, and November 2022.

R13
- two proair HFA expired May 2020, and September 28, 2020;
- fluticasone propionate nasal spray USP expired May 2022;
- debrox earwax removal aid expired May 10,

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| 01890 | Continued From page 40<br>2022; and<br>- clotrimazole cream USP expired April 2022.<br><br>R14<br>- miralax expired February 2022.<br><br>On February 28, 2023, at 11:04 a.m., registered nurse (RN)-B stated all medications were supposed to be labeled and expired medication would be removed from medication carts and destroyed by the nurses at the facility unless it was a medication provided by family.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01890 | | |
| 01940 SS=F | 144G.72 Subd. 3 Individualized treatment or therapy managemen<br><br>For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following:<br>(1) a statement of the type of services that will be provided;<br>(2) documentation of specific resident instructions relating to the treatments or therapy administration;<br>(3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel;<br>(4) procedures for notifying a registered nurse or | 01940 | | |

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| 01940 | Continued From page 41<br>appropriate licensed health professional when a problem arises with treatments or therapy services; and<br>(5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview, and record review, the licensee failed to develop a treatment management plan to include all required content for two of two residents (R3, R17, R18).<br><br>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).<br><br>The findings include:<br><br>R2<br>R2's signed service plan dated January 18, 2023, indicated R2 received assistance with AM and PM cares, medication set up, on-going reassessments, medication administration, laundry, monthly vitals, weekly showers, toileting, 2 hour safety checks at night, and escorts.<br><br>R3 | 01940 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| 01940 | Continued From page 42<br><br>R3's service plan signed on January 30, 2023, indicated R3 received assistance with AM cares using hoyer transfer, catheter cares, medication set up, 90-day reassessment, medication administration, blood glucose check, turn and reposition and toileting.<br><br>R3's physician order sheet dated February 8, 2023, indicated R3 was ordered to receives accuchecks as needed for for symptoms of low blood sugar.<br><br>R17<br>R17's undated service plan indicated R17 received services for medication set up, 90-day reassessment, medication administration, blood glucose monitoring, laundry, and toileting.<br><br>R17's physician order sheet dated January 9, 2023, indicated R17 was ordered to receives accuchecks four times daily, and insulin injections.<br><br>R18's undated service plan indicated R18 received services for medication set up, 90-day reassessment, medication administration, catheter cares, shower, laundry, and toileting.<br><br>R18's Service Checkoff List dated February 1, 2023, through February 28, 2023, indicated R18 was receiving AM and PM Cares which included catheter cares.<br><br>R2, R3, R17, and R18's record lacked required content to include:<br>- statement of type of services that would be provided;<br>- resident specific instructions related to the treatments/therapy administration;<br>- identification of treatment or therapy tasks that | 01940 | | |

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| 01940 | Continued From page 43<br>would be delegated to unlicensed personnel;<br>- process for notifying a registered nurse (RN) or appropriate licensed health professional when an issue or concern arose; and<br>- resident specific requirements related to documentation of treatments/therapy received, verification that it was administered as prescribed and monitoring to prevent possible complications and/or adverse reactions.<br><br>On February 28, 2023, at 12:58 p.m., RN-B verified R2, R3, R17 and R18's records were missing required content. RN-A stated the licensee had been using the same format for all resident records and did not realize it was lacking content. RN-B further stated licensee would need to update all resident records to reflect the requirement.<br><br>The licensee's treatment & Therapy Management Plan policy dated August 1, 2021, indicated for each resident at Southview Senior Communities (management company) receiving management of ordered or prescribed treatments or therapy services, the facility would prepare and include in the service plan a written statement of the treatment or therapy services that would be provided to the resident.<br><br>No further information was provided<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01940 | | |

Minnesota Department of Health
Food, Pools, and Lodging Services
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *02/27/23*
Time: 13:20:00
Report: 1013231056

# Food and Beverage Establishment Inspection Report



**Location:**
Arbor Lakes Senior Living Llc
12001 80th Avenue North
Maple Grove, MN55369
Hennepin County, 27

**Establishment Info:**
ID #: 0037515
Risk:
Announced Inspection: No

**License Categories:**

Expires on: / /

**Operator:**

Phone #: 7635757021
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.

**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.

NUMEROUS OPEN PACKAGES OF READY-TO-EAT TCS FOODS WERE DATE MARKED OVER 7 DAYS PRIOR TO INSPECTION LOCATED IN THE COOK LINE COOLER: ROAST BEEF 2/13, ROAST BEEF 1/20, TURKEY 2/20. COMPLY WITH ABOVE RULE. DISCUSSED DATE MARKING PROCEDURES AND FOOD DISCARDED

*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.

A PAN OF COMMERCIALLY PROCESSED SLICED TOMATOES WERE STORED IN THE WALK-IN COOLER WITHOUT A DATE MARK. PER STAFF THE FOOD WAS PLACED IN THE PAN ON 2/25/23. COMPLY WITH ABOVE RULE. STAFF DATE MARKED THE FOOD.

*Corrected on Site*

**4-600 Cleaning Equipment and Utensils**

4-601.11C

MN Rule 4626.0840C Clean non-food contact surfaces of equipment and maintain free of accumulations of dust, dirt, food residue, and other debris.

DEBRIS AND GRIME WERE ON THE BOTTOM INSIDE OF THE VULCAN OVEN. CLEAN AND MAINTAIN CLEAN. COMPLY WITH ABOVE RULE. DISCUSSED CLEANING PROCEDURES AND REQUESTED STAFF CLEAN THE OVEN.

*Comply By: 02/27/23*

**4-600 Cleaning Equipment and Utensils**

4-602.11E

MN Rule 4626.0845E Clean surfaces contacting food that is not TCS: 1. at any time when contamination may have occurred; 2. at least once every 24 hours for iced tea dispensers and consumer self-service utensils; 3. before restocking consumer self-service equipment and utensils such as condiment dispensers, and display containers; 4. at a frequency specified by the manufacturer or at a frequency necessary to preclude accumulation of soil or mold for ice bins, beverage dispensing nozzles, enclosed components of ice makers, cooking oil storage tanks and distribution lines, beverage and syrup dispensing lines or tubes, coffee bean grinders, and water vending equipment.

GRIME WAS ON THE NOZZLES OF THE NESCAFE MACHINE IN THE BEVERAGE SERVICE AREA. PER MANUFACTURER LABEL THE NOZZLE AREA SHOULD BE CLEANED DAILY. COMPLY WITH ABOVE RULE. REVIEWED CLEANING PROCEDURES AND REQUESTED STAFF CLEAN BEVERAGE DISPENSER.

*Comply By: 02/27/23*

**Surface and Equipment Sanitizers**

Quaternary Ammonia: = 400 ppm at Degrees Fahrenheit
Location: 3-compartment sink
Violation Issued: No

Quaternary Ammonia: = 300 ppm at Degrees Fahrenheit
Location: Sanitizer - cook line
Violation Issued: No

Hot Water: = at 161 Degrees Fahrenheit
Location: Dish machine
Violation Issued: No

**Food and Equipment Temperatures**

Process/Item: Mashed potatoes
Temperature: 172 Degrees Fahrenheit - Location: Steam table
Violation Issued: No

Process/Item: Fish
Temperature: 156 Degrees Fahrenheit - Location: Steam table
Violation Issued: No

Process/Item: Butter
Temperature: 38 Degrees Fahrenheit - Location: Low cooler
Violation Issued: No

Process/Item: Roast beef
Temperature: 39 Degrees Fahrenheit - Location: Cook line cooler
Violation Issued: No

Process/Item: Turkey
Temperature: 39 Degrees Fahrenheit - Location: Cook line cooler
Violation Issued: No

Process/Item: Yogurt
Temperature: 40 Degrees Fahrenheit - Location: 2 door cooler
Violation Issued: No

Process/Item: Milk
Temperature: 41 Degrees Fahrenheit - Location: 2 door cooler
Violation Issued: No

Process/Item: Sliced melon
Temperature: 40 Degrees Fahrenheit - Location: Walk-in cooler
Violation Issued: No

Process/Item: Turkey
Temperature: 40 Degrees Fahrenheit - Location: Walk-in cooler
Violation Issued: No

| Total Orders In This Report | Priority 1 | Priority 2 | Priority 3 |
|---|---|---|---|
| | 1 | 1 | 2 |

The inspection was completed with the operator and reviewed with MDH Nurse Evaluator R. Makela.

Discussed staff illness policy, ware washing, sanitizer, date marks, serving a highly susceptible population, temperature control, cleaning, final cook temperatures, cooling, hand washing, and food handling procedures.

# Food and Beverage Establishment Inspection Report



**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 1013231056 of 02/27/23.

Certified Food Protection Manager: Dennis Ferguson

Certification Number: 102115 Expires: 10/25/25

**Inspection report reviewed with person in charge and emailed.**

Signed: _____

Bjorn Horgen
Residence Director

Signed: JM

Jerry Malloy
Public Health Sanitarian
FPLS Metro
651-201-3998
jerry.malloy@state.mn.us