Electronically delivered

April 17, 2023

Licensee
Broadwell Plymouth Senior Living
3025 North Harbor Lane
Plymouth, MN 55447

RE: Project Number(s) SL37869015

Dear Licensee:

On April 10, 2023, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on December 2, 2022. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the December 16, 2022 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey completed on December 16, 2022, found not corrected at the time of the April 10, 2023, follow-up survey and/or subject to penalty assessment are as follows:

1490-Training Required Relating To Dementia-144g.63 Subd. 4

The details of the violations noted at the time of this follow-up survey completed on April 10, 2023 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, no immediate fines are assessed.

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.

IMPOSITION OF FINES:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

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

Please address your cover letter for reconsideration requests to:

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

We urge you to review these orders carefully. If you have questions, please contact Carrie Euerle at 651-242-8806.

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.

Sincerely,

Carrie Euerle, Interim Supervisor
State Rapid Response Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64970
St. Paul, MN 55164-0970
Telephone: 651-242-8846 Fax: 651-215-6894

PMB

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37869	A. BUILDING: ______ B. WING ______	R 04/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROADWELL PLYMOUTH SENIOR LIVING	**3025 NORTH HARBOR LANE PLYMOUTH, MN 55447**

(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 re- 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: SL37869015 On April 4, 2023 to April 10, 2023, the Minnesota Department of Health conducted a desk survey re-visit at the above provider, and the following correction orders are re- issued. At the time of the follow-up visit there were 55 residents receiving services under the provider's Provisional Assisted Living Facility 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 Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL	

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37869	A. BUILDING: ______ B. WING ______	R 04/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROADWELL PLYMOUTH SENIOR LIVING	**3025 NORTH HARBOR LANE PLYMOUTH, MN 55447**

(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}	Continued From page 1	{0 000}	ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
{01490} SS=E	144G.63 Subd. 4 Training required relating to dementia All direct care staff and supervisors providing direct services must demonstrate an understanding of the training specified in section 144G.64. This MN Requirement is not met as evidenced by: Based on record review, the licensee failed to ensure all staff received dementia care training as required for 4 out of 25 unlicensed personnel, (ULP)-O, ULP-Q, ULP-V, and ULP-X). with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On April 4, 2023 at 4:50 p.m., documents were provided via email, for survey staff to review. On April 7, 2023 at 1:05 p.m., documents were provided via email, for survey staff to review. Documents were reviewed by survey staff on April 4, 2023 at 8:00 a.m. and April 10, 2023 at 8:00	{01490}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37869	A. BUILDING: ______ B. WING ______	R 04/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROADWELL PLYMOUTH SENIOR LIVING	**3025 NORTH HARBOR LANE PLYMOUTH, MN 55447**

(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
{01490}	Continued From page 2	{01490}		

a.m.

The following personnel files did not include the required dementia training:

ULP-O
ULP-O was hired on June 14, 2022. to provide supervision to direct care staff.

ULP-O's employee record lacked documentation of completion of eight hours of initial training within 120 working hours of first day of employment.

ULP-Q
ULP-Q was hired on December 27, 2022, to provide direct care and supervision of care to residents and supervision of unlicensed personnel.

ULP-Q's employee record lacked documentation of completion of eight hours of initial training within 120 working hours of first day of employment.

ULP-V
ULP-V was hired on January 3, 2022, to provide direct care and supervision of care to residents and supervision of unlicensed personnel.

ULP-V's employee record lacked documentation of completion of eight hours of initial training within 120 working hours of first day of employment.

ULP-X
ULP-X was hired on October 17, 2022, to provide direct care and supervision of care to residents and supervision of unlicensed personnel.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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
{01490}	Continued From page 3	{01490}		

ULP-X's employee record lacked documentation of completion of eight hours of initial training within 120 working hours of first day of employment.

During an interview with LALD-A on April 10, 2023 at 12:11 p.m., the LALD-A stated ULP-O, ULP-Q, ULP-V, and ULP-X did not have the initial required dementia training nor did any of them have written proof of previously completed required dementia training with in the past eighteen months.

The licensee's Dementia Care Training policy, dated October 12, 2021, indicated:

Section 1. Employees who had not completed their initial dementia care training will not provide direct care independently.

Section 2. Direct-care employees will:
A & B:
i. complete a minimum of eight hours of initial training on dementia care topics.
ii. initial training will be completed within 80 working hours of the employment start date.
C: Non-Direct care employees will:
i. complete a minimum of four hours of initial training on dementia care topics.
ii. initial training will be completed within 120 working hours of the employment start date.

No further information was provided.

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

February 24, 2023

Licensee
Broadwell Plymouth Senior Living
3025 North Harbor Lane
Plymouth, MN 55447

RE: Project Number(s) SL37869015

Dear Licensee:

On February 22, 2023, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine correction of orders found on the evaluation completed on December 16, 2022. This follow-up evaluation determined your facility had not corrected all of the state licensing orders issued pursuant to the December 16, 2022 evaluation.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state licensing orders issued pursuant to the last evaluation completed on December 16, 2022, found not corrected at the time of the February 22, 2023, follow-up evaluation and/or subject to penalty assessment are as follows:

1490-Training Required Relating To Dementia-144g.63 Subd. 4

The details of the violations noted at the time of this follow-up evaluation completed on February 22, 2023 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, no immediate fines are assessed.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), by the correction order date, the licensee must document in the provider's records any action taken to comply with the correction order by the correction order date. The commissioner may request a copy of this documentation and the assisted living facility's action to respond to the correction orders in future evaluations, upon a complaint investigation, and as otherwise needed.

IMPOSITION OF FINES:

Level 1: no fines or enforcement.

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

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

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

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order 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

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. Requests for hearing may be emailed to: **Health.HRD.Appeals@state.mn.us**.

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

We urge you to review these orders carefully. If you have questions, please contact Carrie Euerle at 651-242-8846.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Sincerely,

Carrie Euerle, Supervisor
Health Regulation Division
State Rapid Response Team
85 East Seventh Place, Suite 220
P.O. Box 64970
St. Paul, MN 55164-0970
Email: carrie.euerle@state.mn.us
Phone: 651-242-8846 Fax: 651-215-5963

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37869	A. BUILDING: ______ B. WING ______	R 02/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROADWELL PLYMOUTH SENIOR LIVING	**3025 NORTH HARBOR LANE PLYMOUTH, MN 55447**

(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 re- 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: SL# SL37869015 On February 21, 2023, and February 22, 2023, the Minnesota Department of Health conducted a desk survey re-visit at the above provider, and the following correction orders are re- issued. At the time of the follow-up visit there were 33 residents receiving services under the provider's Provisional Assisted Living Facility license.	{0 000}		
{01490} SS=E	144G.63 Subd. 4 Training required relating to dementia All direct care staff and supervisors providing direct services must demonstrate an understanding of the training specified in section 144G.64. This MN Requirement is not met as evidenced by: Based on record review, the licensee failed to ensure all staff received dementia care training as	{01490}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37869	A. BUILDING: ______ B. WING ______	R 02/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROADWELL PLYMOUTH SENIOR LIVING	**3025 NORTH HARBOR LANE PLYMOUTH, MN 55447**

(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
{01490}	Continued From page 1	{01490}		

required for three of six employees: Licensed Assisted Living Director(LALD)-A, Registered Nurse/(RN)-B and Business Office Personnel (ADM)-E with records reviewed.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).

The findings include:

On February 21, 2023, at 2:31 a.m., documents were provided via email, for survey staff to review.

Documents were reviewed by survey staff on February 22, 2023 at 10:00 a.m..

The following personnel files did not include the required dementia training:

LALD-A
LALD-A was hired on April 12, 2022. to provide supervision to direct care staff.

LALD's employee record lacked documentation of completion of eight hours of initial training within 120 working hours of first day of employment.

RN-B
RN-B was hired on September 15,2022, to provide direct care and supervision of care to residents and supervision of unlicensed personnel.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROADWELL PLYMOUTH SENIOR LIVING	**3025 NORTH HARBOR LANE PLYMOUTH, MN 55447**

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{01490}	Continued From page 2 RN-B's employee record lacked documentation of completion of eight hours of initial training within 120 working hours of first day of employment. ADM-E ADM-E was hired on September 6, 2022, to provide non-direct care and services to residents. ADM-E's employee record lacked documentation of completion of four hours of initial training within 160 working hours of first day of employment. LALD-A's email dated February 22, 2023 at 1:45pm indicated the licensee had enrolled all staff in a nine-hour dementia training bundle course. Policy: The licensee's Dementia Care Training policy, dated October 12, 2021, indicated: Section 1. Employees who had not completed their initial dementia care training will not provide direct care independently. Section 2. Direct-care employees will: A & B: i. complete a minimum of eight hours of initial training on dementia care topics. ii. initial training will be completed within 80 working hours of the employment start date. C: Non-Direct care employees will: i. complete a minimum of four hours of initial training on dementia care topics. ii. initial training will be completed within 120 working hours of the employment start date.	{01490}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROADWELL PLYMOUTH SENIOR LIVING	**3025 NORTH HARBOR LANE PLYMOUTH, MN 55447**

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{01490}	Continued From page 3 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	{01490}		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

January 20, 2023

Licensee
Broadwell Plymouth Senior Living
3025 North Harbor Lane
Plymouth, MN 55447

RE: Project Number(s) SL37869015

Dear Licensee:

This is your **official notice** that you have been **granted your assisted living facility license.** Your license effective and expiration dates remain the same as on your provisional license. Your updated status will be listed on the license certificate at renewal and **this letter serves as proof** in the meantime. If you have not received a letter from us with information regarding renewing your license within 60 days, please contact us at (651) 201-5273 or by email at Health.assistedliving@state.mn.us.

The Minnesota Department of Health completed an initial evaluation on December 16, 2022, for the purpose of 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.

STATE 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 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 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 residents/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

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

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

Please address your cover letter for general 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

Free from Maltreatment reconsideration requests should addressed 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,

Carrie Euerle, Interim Supervisor
State Rapid Response Team
85 East Seventh Place, Suite 220
P.O. Box 64970
St. Paul, MN 55164-0970
Telephone: 651-201-5984 Fax: 651-281-9796

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37869	A. BUILDING: ______ B. WING ______	12/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROADWELL PLYMOUTH SENIOR LIVING	**3025 NORTH HARBOR LANE PLYMOUTH, MN 55447**

(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 ORDERS 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: SL37869015 On December 12, 2022 through December 16, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey and investigation, there were 31 residents receiving services under the provider's Provisional Assisted Living Facility license.	0 000	Assisted Living Provider 144G. 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 Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	37869		12/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROADWELL PLYMOUTH SENIOR LIVING	**3025 NORTH HARBOR LANE PLYMOUTH, MN 55447**

(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	Continued From page 1	0 000	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 (13) offer to provide or make available at least the following services to residents: (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 fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	0 480		

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0 480	Continued From page 2 or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated (DATE), for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
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 e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional 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. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to post the required information related to the grievance procedure and contact information for the Office of Ombudsman for Long-Term Care and Mental Health and Developmental Disabilities. This had the potential to affect all residents receiving assisted living services, staff, and visitors.	0 550		

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0 550	Continued From page 3 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On December 12, 2022, at 12:10 p.m., during a tour of the licensee, the Minnesota Department of Health, (MDH) surveyors observed a lack of posting for a grievance procedure in a common areas, which included the name, telephone number, and e-mail contact information for the individuals who were responsible for handling resident grievances. In addition, there was no posting in the common area regarding contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. When interviewed on December 12, 2022, at 12:30 p.m., licensed assisted living director (LALD)-A, confirmed the required information was not posted in the common areas of the licensee. The licensee's Resident Handbook, dated October 2021, included the following: - page 11, the licensee will post all phone contacts for advocacy agencies, in the community. -page 18, the licensee will post	0 550		

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0 550	Continued From page 4 Ombudsman contact information in the community. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 550		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c 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: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (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 (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post information and the reporting number for the Minnesota Adult Abuse Reporting Center (MAARC) to report suspected maltreatment of a vulnerable adults under section 626.557 and posted 911 signage in common areas. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a	0 640		

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0 640	Continued From page 5	0 640		

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

The Findings include:

On December 12, 2022 at 12:10 p.m., during a tour of the licensee, the Minnesota Department of Health (MDH) surveyors observed a lack of postings for MAARC information and 911 signage in any of the common areas of the building.

When interviewed on December 12,2022 at 12:30 p.m., (LALD)-A, confirmed the required information was not posted in the common areas of the facility.

The licensee's Resident Handbook, dated October 2021, included the following:

-page 9: All staff members are required to report abuse to the LALD, who will then report to the local agencies/law enforcement.

-page 11: indicated the licensee will post all phone contacts for advocacy agencies, in the community.

No further information provided.

TIME PERIOD TO CORRECT: Twenty-one (21) Days

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0 660	Continued From page 6	0 660		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC). The licensee failed to update the licensee's TB Policy and failed to provide TB training for three of three employees (Registered Nurse/RN)-B, Unlicensed Personnel/(ULP)-C and ULP-D), with employee records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic	0 660		

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0 660	Continued From page 7	0 660		

failure that has affected or has the potential to affect a large portion or all of the residents).

The findings include:

On December 13, 2022, documents were provided at approximately 4:01 p.m., via email, for survey staff to review.

Documents were reviewed by survey staff on December 13, 2022 through December 16, 2022.

The following personnel files did not include TB training and TB symptom screening at the time of hire:

RN-B
RN-B was hired on September 15, 2022, to provide direct care and supervision of care to residents and supervision of unlicensed personnel.

On December 12, 2022, the surveyors observed RN-B provide supervision of unlicensed personnel (ULP) and residents.

RN-B's employee record lacked evidence of required TB training and symptom screen at the time of hire.

ULP-C
ULP-C was hired on September 21, 2022, to provide direct care services to licensee's residents.

On December 12, 2022, at 2:00 p.m., the surveyors observed ULP-C provide medication administration services to R1.

ULP-C's employee record lacked evidence of

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0 660	Continued From page 8 required TB training at the time of hire. ULP-D ULP-D was hired on September 13, 2022, to provide direct care services to the licensee's residents. On December 12, 2022, at 12:30p.m., the surveyors observed ULP-D providing direct care to residents in the licensee's memory care unit. ULP-D had a signed job description of memory care manager, signed, and dated by ULP-D on December 12, 2022. ULP-D's employee record lacked evidence of required TB training at the time of hire or the change in positions. During an interview dated December 23, 2022, at 10:00 a.m., licensed marketing director, (ADM)-G, confirmed RN-B, ULP-C, and ULP-D did not have the required TB training in their employee files. The licensee's Tuberculosis Policy dated April, 2021, indicated the operator of each assisted living building shall ensure the licensee's compliance with the department's tuberculosis guidelines. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness	0 680		

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0 680	Continued From page 9 (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed prominently post an emergency preparedness plan prominently. This had the potential to affect all residents receiving services under the assisted living license, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	0 680		

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0 680	Continued From page 10 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 December 12, 2022, at 12:10 p.m., during a tour of the licensee, the Minnesota Department of Health, (MDH) surveyors observed a lack of posting of an emergency disaster plan posted prominently in common areas of the building. On December 12, 2022 at 12:30 p.m., MDH surveyors requested to review the licensee's emergency preparedness posting. The licensee confirmed during interview they were not aware of where the emergency plan was posted in the licensee's community areas. A licensee handbook, dated October 2021, indicated emergency disaster evacuation information will be posted in the community. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
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 11	0 800		

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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).

The findings include:

On December 13, 2022, between 11:10 a.m. and 12:45 p.m., survey staff toured the facility with the business office manager (ADM)-E.

During the facility tour, survey staff observed the following:

1. There was an open electrical outlet box above the door in the garage.
2. Electrical panels were obstructed in the first-floor nursing office.

During the facility tour interview, ADM-E confirmed the findings.

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TIME PERIOD FOR CORRECTION: Seven (7) days

0 810 SS=F — 144G.45 Subd. 2 (b)-(f) Fire protection and physical environment — 0 810

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

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This MN Requirement is not met as evidenced by:
Based on a record review and interview, the licensee failed to develop a fire safety and evacuation plan with the required elements and failed to provide required employee and resident training on fire safety and evacuation. This deficient practice had the ability to affect all staff, residents, and visitors.

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

The findings include:

On December 13, 2022, between 11:10 a.m. and 12:45 p.m., survey staff toured the facility with the business office manager (ADM)-E. During the facility tour, survey staff observed that the location and number of resident sleeping rooms were not included on the evacuation plans posted in the facility. During the facility tour interview, ADM-E confirmed the findings.

On December 13, 2022, at approximately 12:50 p.m., documents were provided for review. Record review of the available documentation indicated that the licensee did not develop and maintain fire safety and evacuation plans for the facility location.
1. The H-130 plan for resident evacuation of memory care dated 4-13-21 and the H-100 plan for fire emergency evacuation dated 10-6-21 were templates from Seasons Living with

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references to Hawaii and Oklahoma. These plans included employee actions during a fire watch but did not specify how to move or evacuate residents in the event of a fire or similar emergency from this facility.
These plans failed to include:
a. The location and number of resident sleeping rooms.
b. Employee actions to be taken in the event of a fire or similar emergency.
c. Fire protection procedures necessary for residents.
d. 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.

2. The fire emergency plan included employee actions, but the plan did not specify how to move or evacuate residents in the event of a fire or similar emergency from this facility location. The location and number of resident sleeping rooms were not included as part of the plan.

3. Record review of available documentation indicated that the licensee did not provide employee training on the fire safety and evacuation plan twice per year after the initial hire training. The H-100 policy states that employees are trained on fire emergency plans upon hire. No additional training on fire safety and evacuation plans was specified. The licensed assisted living director (LALD)-A explained during an interview, on December 13, 2022, at approximately 1:25 p.m., that employees complete additional fire prevention and response training using an online educational program.

4. Record review of the available documentation

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BROADWELL PLYMOUTH SENIOR LIVING	**3025 NORTH HARBOR LANE PLYMOUTH, MN 55447**

(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
0 810	Continued From page 15 indicated that the licensee did not provide annual training to residents who can assist in their own evacuation on the proper actions to take in the event of a fire to include movement, evacuation, or relocation as required by statute. The plans state that new residents are trained when they move in, but no additional training frequency was specified. Records were not provided to support that annual resident training had been completed. On December 13, 2022, at approximately 1:25 p.m., the LALD-A confirmed during an interview that the facility failed to provide the required content within the fire safety and evacuation plans, including training frequency. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01290 SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits.	01290		

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01290	Continued From page 16	01290		

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to ensure a background study was submitted and received for two of three employees (unlicensed personnel/ULP)-C and (ULP)-D, with records reviewed.

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

The findings include:

On December 13, 2022, documents were provided at approximately 4:01 p.m., via email, for survey staff to review.

Documents were reviewed by survey staff on December 13, 2022 through December 16, 2022.

The following personnel files did not include a background study for the following personnel records provided:

ULP-C
ULP-C was hired September 17, 2022 , to provide direct care and services to the licensee's residents.

ULP-C began providing direct care to the licensee's residents after September 27, 2022.

ULP-C's employee record contained a

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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
01290	Continued From page 17 background study, submitted by the licensee's business office manager (ADM)-E, dated December 13, 2022. ULP-C's employee record lacked evidence the licensee submitted a background study prior to December 13, 2022. ULP-D ULP-D was hired September 13, 2022, to provide direct care and services to the licensee's residents. ULP-D began providing direct care to the licensee's residents after September 28, 2022. ULP-D's employee record contained a background study, submitted by the licensee's business office manager (ADM)-E, dated November 5, 2022. ULP-D's employee record lacked evidence the licensee submitted a background study prior to November 5, 2022. An email provided by the administrator (ADM-E), dated December 23, 2033 at 10:36 a.m., indicated both ULP-C and ULP-D's personnel files were audited by the licensee and both ULP-C and ULP-D did not have background study information on file. During an interview with the licensee's marketing director (ADM)-G, on December 23, 2022, at 9:20 a.m., ADM-G stated during an employee personnel file audit conducted prior to December 13, 2022, it was found that ULP-C did not have a completed background study on file. The Licensee Handbook dated, October 2021,	01290		

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01290	Continued From page 18 page 9, indicated the licensee will conduct background checks and will not employee anyone who had been convicted of abusing, neglecting or mistreating individuals. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days to correct. Corrected December 13, 2022, during survey period.	01290		
01490 SS=D	144G.63 Subd. 4 Training required relating to dementia All direct care staff and supervisors providing direct services must demonstrate an understanding of the training specified in section 144G.64. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure all staff received dementia care training as required for two of three employees (Registered Nurse/RN)-B and (unlicensed personnel/ULP-C) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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).	01490		

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01490	Continued From page 19	01490		

The findings include:

On December 13, 2022, documents were provided at approximately 4:01 p.m., via email, for survey staff to review.

Documents were reviewed by survey staff on December 13, 2022 through December 16, 2022.

The following personnel files did not include the required dementia training records for the following personnel:

RN-B
RN-B was hired on September 15,2022, to provide direct care and supervision of care to residents and supervision of unlicensed personnel.

On December 12, 2022, the surveyors observed RN-B provide supervision of unlicensed personnel (ULP)s and residents.

RN-B's employee record lacked documentation of completion of eight hours of initial training within 120 working hours of first day of employment.

ULP-C
ULP-C was hired on September 21, 2022, to provide direct care and services to licensee's residents.

On December 12, 2022, at 2:00 p.m., the surveyors observed ULP-C provide medication administration services to R1.

ULP-C's record lacked documentation of completion of eight hours of initial training within 160 working hours of the first day of employment.

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01490	Continued From page 20 During an interview dated December 23, 2022, at 10:00 a.m. licensee marketing director (ADM)-G, acknowledged RN-B and ULP-C personnel files did not include the required eight hours of dementia care initial training within 160 working hours of employment. ADM-G stated RN-B was currently working with a contracted staffing agency and would be hired on permanently at the licensee in 2023. ADM-G stated she would request documentation from the agency to identify if the agency had any completed dementia training for RN-B, as the licensee did not have this information. The licensee's Dementia Care Training policy, dated October 12, 2021, indicated: Section 1. Employees who had not completed their initial dementia care training will not provide direct care independently. Section 2. Direct-care employees will: i. completes a minimum of eight hours of initial training on dementia care topics. ii. initial training will be completed within 80 working hours of the employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01490		
01880 SS=D	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and	01880		

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01880	Continued From page 21	01880		

permit only authorized personnel to have access.

This MN Requirement is not met as evidenced by:
Based on observation, interview and record review, the licensee failed to ensure prescription medications were stored in a secured manner allowing only authorized personnel access for one of four (R1) residents with medication storage observed.

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

The findings include:

On December 12, 2022 at approximately 2:12 p.m., a medication was observed to be in an unlocked location of a resident's (R1) room.

R1 was admitted to the assisted living facility on September 20, 2022, with the diagnoses of Parkinson's and anxiety.

R1's nursing assessment dated October 7, 2022, indicated R1 needed daily staff assistance with all medication.

During a tour of the licensee, on December 12, 2022 at 12:25 p.m., The Minnesota Department of Health (MDH) surveyors observed medications to be stored in a locked medication room that contained a locked medication cart on the

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01880	Continued From page 22 memory care unit. MDH surveyors observed medication administration on December 12, 2022 at 2:00 p.m. The assisted living resident medications were stored on the licensee's third floor, in a locked medication room, which contained a locked medication cart, with a separate locked drawer inside the cart for storage of narcotic medications. On December 12, 2021, at 2:12 p.m., The Minnesota Department of Health (MDH), surveyors observed a bottle of medication (Nystatin) in R1's room next to the kitchen sink. R1's medication administration record (MAR) dated November 2022, did not include a physician's order for Nystatin. On December 12, 2022, at 2:00 p.m., registered nurse (RN)-B, stated all medication should be stored in the medication cart and not in resident rooms. RN-B confirmed there was not a physician's order included on R1's November 2022 MAR for the medication (Nystatin) and the medication should not be stored in R1's room. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the	02040		

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02040	Continued From page 23 following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide a hazard vulnerability assessment or safety risk assessment of the physical environment on and around the property for the facility. This deficient practice had the ability to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On December 13, 2022, at approximately 12:50 p.m., documents were provided for review. Documents were reviewed by survey staff on December 13, 2022, between 12:50 p.m. and 1:20 p.m. A hazard vulnerability or safety risk assessment for the property was not included in the documentation. The assessment was requested by survey staff but not provided. On December 13, 2022, at 1:25 p.m., the LALD-A	02040		

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02040	Continued From page 24 confirmed during an interview that the licensee had not completed a hazard vulnerability or safety risk assessment on and around the property. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
02240 SS=C	144G.90 Subdivision 1 Assisted living bill of rights; notification (a) An assisted living facility must provide the resident a written notice of the rights under section 144G.91 before the initiation of services to that resident. The facility shall make all reasonable efforts to provide notice of the rights to the resident in a language the resident can understand. (b) In addition to the text of the assisted living bill of rights in section 144G.91, the notice shall also contain the following statement describing how to file a complaint or report suspected abuse: "If you want to report suspected abuse, neglect, or financial exploitation, you may contact the Minnesota Adult Abuse Reporting Center (MAARC). If you have a complaint about the facility or person providing your services, you may contact the Office of Health Facility Complaints, Minnesota Department of Health. You may also contact the Office of Ombudsman for Long-Term Care or the Office of Ombudsman for Mental Health and Developmental Disabilities." (c) The statement must include contact information for the Minnesota Adult Abuse Reporting Center and the telephone number, website address, e-mail address, mailing address, and street address of the Office of Health Facility Complaints at the Minnesota	02240		

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02240	Continued From page 25 Department of Health, the Office of Ombudsman for Long-Term Care, and the Office of Ombudsman for Mental Health and Developmental Disabilities. The statement must include the facility's name, address, e-mail, telephone number, and name or title of the person at the facility to whom problems or complaints may be directed. It must also include a statement that the facility will not retaliate because of a complaint. (d) A facility must obtain written acknowledgment from the resident of the resident's receipt of the assisted living bill of rights or shall document why an acknowledgment cannot be obtained. Acknowledgment of receipt shall be retained in the resident's record. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the current Minnesota Bill of Rights for Assisted Living Residents was provided and a written acknowledgement was received for three of three residents (R1, R3, and R4) with records reviewed. This practice resulted in a level one violation (a violation that has not potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On December 13, 2022, at approximately 3:43 p.m., documents were provided via encrypted, email, for review.	02240		

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02240	Continued From page 26 Documents were reviewed by survey staff on December 13, 2022, between 3:43 p.m. and 4:30 p.m. The following residents, (R1), (R3) and (R4's) records lacked signed resident's bill of rights: R1 R1 began receiving assisted living services on September 20, 2022. R1's record lacked evidence the current bill of rights, a written acknowledgement, and the process for filing a complaint was signed by the resident upon admission. The resident's current bill of rights was signed by R1 on December 26, 2022. R3 R3 began receiving assisted living services on September 22, 2022. R3's record lacked evidence the current bill of rights, a written acknowledgement, and the process for filing a complaint was signed by the resident upon admission. The resident's current bill of rights was signed by R3 on December 26, 2022. R4 R4 began receiving assisted living services on November 14, 2022. R4's record lacked evidence the current bill of rights, a written acknowledgement, and the process to for filing a complaint was signed by the resident upon admission. When interviewed on December 12, 2022, at 12:30 p.m., licensed assisted living director (LALD)-A, confirmed the required information and acknowledgement regarding the Resident Bill of Rights was not included in R1, R3, or R4's record.	02240		

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The licensee's Resident Handbook, dated October 2021, included on page 20 that each resident in the community would be given a copy of the Resident Bill of Rights and Responsibilities.

No further information was provided.

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

DEPARTMENT OF HEALTH

Type: Full
Date: *12/12/22*
Time: 11:00:00
Report: 1036221129

Food and Beverage Establishment Inspection Report

Location:
Broadwell Plymouth Senior Livi
3025 North Harbor Lane
Plymouth, MN55447
Hennepin County, 27

Establishment Info:
ID #: 0037944
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 5036753925
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.

4-300 Equipment Numbers and Capacities

4-302.13A ** Priority 2 **

MN Rule 4626.0710A Provide a readily accessible temperature measuring device for measuring the washing and sanitizing temperatures in manual warewashing operations.

NO TEMPERATURE MEASURING DEVICE ON SITE FOR MEASURING TEMPERATURE OF HIGH TEMP DISH MACHINE. OBTAIN AND MAINTAIN SUCH A DEVICE.

Comply By: 12/27/22

4-200 Equipment Design and Construction

4-204.11

MN Rule 4626.0565 Prevent grease or condensation from exhaust ventilation hood systems from draining or dripping onto food, equipment, utensils, linens, single-service articles, and single-use articles.

OBSERVED SOME GREASE BUILDUP ON THE VENTS IN THE HOOD ABOVE THE STOVE. CLEAN AT A GREATER FREQUENCY TO PREVENT SUCH ACCUMULATION.

Comply By: 12/27/22

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.

OBSERVED SOME BUILT UP FOOD DEBRIS ON THE CAN OPENER. ISSUE CORRECTED ON SITE.

Corrected on Site

Surface and Equipment Sanitizers

Hot Water: = at 177.8 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

QUATERNARY AMMONIA: = 200PPM at Degrees Fahrenheit
Location: DINING AREA SANI BUCKET
Violation Issued: No

QUATERNARY AMMONIA: = 200PPM at Degrees Fahrenheit
Location: KITCHEN SANI BUCKET
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Hold/SHRED CHEESE
Temperature: 38 Degrees Fahrenheit - Location: WALK IN COOLER
Violation Issued: No

Process/Item: Ambient Temp
Temperature: 37 Degrees Fahrenheit - Location: WALK IN COOLER
Violation Issued: No

Process/Item: Ambient Temp
Temperature: -5 Degrees Fahrenheit - Location: WALK IN FREEZER
Violation Issued: No

Process/Item: Ambient Temp
Temperature: 3 Degrees Fahrenheit - Location: HOSHIZAKI FREEZER
Violation Issued: No

Process/Item: Ambient Temp
Temperature: -5 Degrees Fahrenheit - Location: NORLAKE FREEZER
Violation Issued: No

Process/Item: Ambient Temp
Temperature: 37 Degrees Fahrenheit - Location: NORLAKE COOLER
Violation Issued: No

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

INSPECTION WAS CONDUCTED WITH LEMARK BARNES. INSPECTION WAS REVIEWED WITH HRD NURSE EVALUATOR, ZALEI LEWIS.

IN ADDITION TO ORDERS ON REPORT, DISCUSSED:
-EMPLOYEE ILLNESS POLICY AND LOG
-HANDWASHING PROCEDURES
-GLOVE USE AND NO BARE HAND CONTACT WITH RTE FOODS
-COOK TEMPS FOR RAW ANIMAL FOODS
-THERMOMETER USE AND CALIBRATION
-SANITIZER USE AND TEST KITS
-DATE LABELING
-PEST CONTROL

Food and Beverage Establishment Inspection Report

THE FACILITY COOKS FOR APPROXIMATELY 50 RESIDENTS AND ALL FOOD IS PREPARED FOR SAME DAY SERVICE.

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

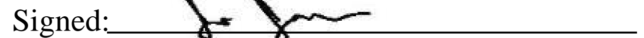
NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the inspection report number 1036221129 of 12/12/22.

Certified Food Protection Manager: Shawn M. Rodriguez

Certification Number: FM102531 Expires: 09/24/25

Inspection report reviewed with person in charge and emailed.



Signed: ______________________ Signed: ______________________

LaMark Barnes
Kitchen Staff

Jeff Johanson