Electronically Delivered

April 12, 2024

Licensee
Olydia Home Care Inc
3904 Gershwin Avenue North
Oakdale, MN 55128

RE: Project Number(s) SL37482015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on February 8, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

STATE CORRECTION ORDERS

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

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

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: jess.schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37482	A. BUILDING: _____ B. WING _____	02/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLYDIA HOME CARE INC	3904 GERSHWIN AVENUE NORTH OAKDALE, MN 55128

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL37482015 On February 5, 2024, through February 7, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were no residents; no residents receiving services under the Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 100 SS=F	144G.10 Subdivision 1 License required (a)(1)Beginning August 1, 2021, no assisted living facility may operate in Minnesota unless it is	0 100		

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

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0 100	Continued From page 2 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to obtain accurate licensure when the licensee applied for the assisted living licensure despite having a single building with four separate residences sharing one roof without having an approved two-hour fire wall. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's health facility identification (HFID) 37482 was located at 3904 Gershwin Avenue North, Oakdale, Minnesota (MN) 55128, and three other attached townhomes. On Tuesday, February 6, 2024, at 10:50 a.m., the engineering surveyor requested, via email, the licensee to submit plans or verification of the facility having a two-hour fire barrier between the assisted living facility and the three other attached townhomes. During an interview on February 6, 2024, at 3:00 p.m., licensed assisted living director (LALD)-A stated they were unsure if there was a two-hour fire barrier between the assisted living facility and the three other attached townhomes and would check with the city to see if building plans were available.	0 100		

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0 100	Continued From page 3 On Friday, February 9, 2024, at 8:09 a.m., the engineering surveyor requested, via email, the licensee to submit plans or verification of the facility having a two-hour fire barrier between the assisted living facility and the three other attached townhomes. On Friday February 9, 2024, at 3:34 p.m., LALD-A sent an email to the City of Oakdale which stated, "Thank you for responding and notifying us that your Building Official is out of the office and will be back next week. This is in regards to property enquiry [sic] 3904 Gershwin Ave N Oakdale MN 55128. [Engineering surveyor] has given [Licensee] an extension to submit this document/information on February 12th, no later than 3:00 pm." On Monday February 12, 2024, at 12:03 p.m., the City of Oakdale, via email, stated, "We do not keep residential plans after a year and do not have any of the original plans from 1981 when this townhome was constructed. He stated there was not a required 2 hour wall between units at that time. There may be two (1) hour walls or just one (1) hour wall, however, the only way to tell would be to open up the wall and see. If you require further information, please reach out to the Building Official for specific code requirements." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 100		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 4 (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated February 6, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following	0 680		

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

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0 680	Continued From page 6 has affected or has the potential to affect a large portion or all of the residents). The findings include: On February 6, 2024, at 11:00 a.m., the surveyor observed the facility postings located on the main level of the facility. The facility lacked an emergency disaster plan posted in a prominent area of the facility. Licensed assisted living director (LALD)-A provided the surveyor the licensee's EPP binder for review. The licensee's EPP dated July 14, 2023, lacked documentation including all the required elements of: -post an emergency disaster plan prominently. On February 6, 2024, at 11:15 a.m., LALD-A stated, she was not aware the EPP was required to be posted. Also, LALD-A verbalized she would get the EPP posted. The licensee's Emergency Preparedness Background policy dated July 14, 2023, included "6. Post an emergency disaster plan on each floor prominently." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code;	0 790		

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0 790	Continued From page 7 (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the portable fire extinguishers as required by statute. This deficient condition had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On February 5, 2024, at 9:45 a.m., survey staff toured the facility with licensed assisted living director/registered nurse (LALD/RN)-A and clinical nurse supervisor/registered nurse (CNS/RN)-B. During the tour, survey staff observed the monthly inspection records were blank on the back of the tags attached to the portable fire extinguishers. Fire extinguisher inspections must be conducted every month to ensure each extinguisher is in its designated	0 790		

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0 790	Continued From page 8 place, it has not been tampered with, and there is no obvious physical damage or condition that would interfere with its use or operation. During an interview on February 6, 2024, at 3:00 p.m., LALD/RN-A and CNS/RN-B verified monthly inspections had not been performed on the fire extinguishers. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	0 800		

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0 800	Continued From page 9 or has the potential to affect a large portion or all of the residents). The findings include: On February 5, 2024, at 9:45 a.m., survey staff toured the facility with licensed assisted living director/registered nurse (LALD/RN)-A and clinical nurse supervisor/registered nurse (CNS/RN)-B. During the tour, survey staff observed the following: 1. The smoke alarm installed in the hallway on the main floor did not work when tested. During an interview on February 6, 2024, at 3:00 p.m., LALD/RN-A and CNS/RN-B verified the smoke alarm was not working properly and stated maintenance had already been contacted to evaluate this smoke alarm. 2. An exit sign was posted over the door leading into the garage from the home. This door was also labeled as an emergency exit on the floor plans. Emergency exits are required to lead directly to the exterior of the building and not through a higher hazard room. During an interview on February 6, 2024, at 3:00 p.m., LALD/RN-A and CNS/RN-B verified this door was improperly designated as an exit and stated the emergency plans would be revised and the exit sign removed. 3. In an unoccupied lower-level resident bedroom, there were holes in the wall and an electrical wall outlet without a cover. During an interview on February 6, 2024, at 3:00 p.m., LALD/RN-A and CNS/RN-B stated the wall would be repaired and a cover installed on the outlet. LALD/RN-A and CNS/RN-B explained the wall was damaged by the resident who had previously occupied this room. 4. The cover was missing on the chime unit for the doorbell. During an interview on February 6,	0 800		

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0 800	Continued From page 10 2024, at 3:00 p.m., LALD/RN-A and CNS/RN-B verified the cover was missing and stated it would be reinstalled. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (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	0 810		

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0 810	Continued From page 11 the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to develop a fire safety and evacuation plan with the required content, and provide required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On February 6, 2024, the licensee provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and employee evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The FSEP included a fire safety policy dated August 1, 2023. This policy was a template and had not been developed for use at the facility. The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The employee	0 810		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 810	Continued From page 12 actions for fire were limited to the acronym RACE (Remove, Alarm, Confine, and Extinguish or Evacuate). The FSEP did not identify specific fire protection procedures for residents evident by limited instructions directing residents to stoop or crawl to avoid smoke. No additional fire protection procedures necessary for residents were included. During an interview on February 6, 2024, at 3:00 p.m., licensed assisted living director/registered nurse (LALD/RN)-A and clinical nurse supervisor/registered nurse (CNS/RN)-B verified the FSEP was a template and had not been developed for use at this facility. TRAINING Record review indicated the licensee failed to provide training to employees on the FSEP upon hire and/or at least twice per year as evident by the lack of training documentation. Emergency preparedness training certificates from a third-party online training platform were submitted for review. No training records to support employee training on the facility FSEP were provided. During an interview on February 6, 2024, at 3:00 p.m., LALD/RN-A and CNS/RN-B verified training records were not available and explained employees were trained on the FSEP but this had not been documented. DRILLS Record review indicated the licensee failed to conduct employee evacuation drills twice per year, per shift with at least one evacuation drill every other month as evident by no fire drill	0 810		

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0 810	Continued From page 13 records for December 2023 and January 2024. Six fire drills were recorded on the 2023 log, these drills were completed in January, March, May, July, September, and November. During an interview on February 6, 2024, at 3:00 p.m., LALD/RN-A and CNS/RN-B verified fire drill records were not provided to support drills had been performed in December 2023 or January 2024, and stated they would email additional drill records by the end of the day if available. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01370 SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to	01370		

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01370	Continued From page 14 perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency to include all required content was completed for one of one unlicensed personnel (ULP)-C. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-C was hired on December 1, 2021, to provide direct cares for the licensee's residents.	01370		

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01370	Continued From page 15 ULP-C's employee record lacked documentation of training and competency in the following topics: -basic nutrition, meal preparation, food safety, and assistance with eating; and -awareness of commonly used health technology equipment and assistive devices. On February 7, 2024, at 2:55 p.m., clinical nurse supervisor (CNS)-B stated she was not able to provide any additional training records for ULP-C. On February 7, 2024, at 4:01 p.m., during the exit conference, licensed assisted living director (LALD)-A stated the additional required training content for ULP-C was not found. The licensee's Staff Competency policy dated August 1, 2021, included "4. Home Health Aides (HHA) providing assisted living services and who have not completed a state-approved formal training and competency evaluation program will demonstrate competency through the following process: a. Satisfactory completion of an oral or written test on the tasks the HHA will perform. Refer to the Competency Manual for criteria; b. Home Health Aides may not work for [Licensee] until they have successfully passed the written and demonstration competency evaluation, including satisfactory completion of the following; i. Observation, reporting and documenting of resident status; ii. Basic knowledge of body functioning and changes in body function, injuries or other reportable changes; iii. Recognizing physical, emotional, cognitive and development needs of the resident; iv. Basic infection control, including blood-borne	01370		

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01370	Continued From page 16 pathogens; v. Maintenance of a clean and safe environment; vi. Falls prevention; vii. Safe transfer techniques and ambulation; viii. Range of motion and positioning; ix. Administering medications or treatments as required; x. Basic nutrition, meal preparation, food safety and assistance with eating; xi. Preparation of modified diets; xii. Communication skills and barriers; xiii. Cultural diversity; xiv. Confidentiality/privacy; xv. Professional boundaries; xvi. Commonly used health technology equipment and assistive devices; c. The following topics must be completed by a practical skills test; i. Appropriate and safe techniques in personal hygiene and grooming, including bathing, hair care, oral hygiene (teeth, gums, and oral prosthetics), care and use of hearing aids, dressing and toileting; ii. Safe transfer techniques and ambulation; iii. Range of motion and positioning; iv. Reading and recording temperature, pulse and respirations; v. Administration of medications and treatments, as required; and vi. Other delegated tasks." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following	01470		

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01470	Continued From page 17 topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following	01470		

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01470	Continued From page 18 topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received orientation to include all required content for one of two employees (clinical nurse supervisor (CNS)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 February 6, 2024, at 9:10 a.m., during the entrance conference, licensed assisted living director (LALD)-A stated the licensee utilized courses from an online education training program for some of the employees' orientation.	01470		

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01470	Continued From page 19 CNS-B was hired on March 29, 2021, and provided direct care services for residents. CNS-B's employee record lacked documentation the following orientation topics were completed: -The principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. On February 7, 2024, at 2:55 p.m., clinical nurse supervisor (CNS)-B stated she will check to see if she could find the person-centered care training for CNS-B's employee record. On February 7, 2024, at 4:00 p.m., LALD-A stated CNS-B was not able to find the documentation for the required person-centered care planning and service delivery initial orientation content. The licensee's Staff Orientation and Education policy dated August 1, 2021, included "3. Orientation topics will include, but not be limited to, the following, g. The principles of person-centered planning and service delivery and how they apply to direct support services provided by staff." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the	01500		

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01500	Continued From page 20 provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and	01500		

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01500	Continued From page 21 challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received at least eight (8) hours of annual training for each 12 months of employment for two of two employees (clinical nurse supervisor (CNS)-B, unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: CNS-B and ULP-C were hired on March 29, 2021, and December 1. 2021, respectively, to provide direct care services for residents. CNS-B and ULP-C's employee records lacked documentation of the required 8 hours of annual training, including the following topic:	01500		

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01500	Continued From page 22 -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. On February 7, 2024, at 4:00 p.m., LALD-A stated, she was not able to find CNS-B or ULP-C's documentation for the required person-centered care planning and service delivery annual training content. Additionally, LALD-A verbalized she would get these documents completed with CNS-B and ULP-C. The licensee's Staff Orientation and Education policy dated August 1, 2021, included "12. All staff providing assisted living services will complete at least eight (8) hours of education for every twelve (12) months of employment. 13. Education topics will include, but not be limited to, the following: a. Reporting of maltreatment of adults; b. Review of Assisted Living Bill of Rights and staff responsibilities related to ensuring the exercise and protection of those rights; c. Review of the organization ' s policies and procedures related to provision of assisted living services and how to implement them; d. Infection control techniques used in the home; e. Effective approaches to use to problem solve when working with a resident ' s challenging behaviors and how to communicate with residents who have dementia, Alzheimer ' s Disease or related disorders; and f. The principles of person-centered planning and service delivery and how they apply to direct support services provided by staff." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		

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01760	Continued From page 23	01760		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to ensure medications were administered per physician's orders for one of one discharged resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1's was admitted on April 1, 2020, and had diagnoses which included but not limited to schizophrenia (a mental health disorder	01760		

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01760	Continued From page 24 characterized by delusions, hallucinations, disorganized thoughts, speech, and behavior), type one diabetes (insulin dependent) chronic obstructive pulmonary disease (lung disease), and hypertension (high blood pressure). R1 was discharged on December 23, 2023. R1's Service Plan signed and updated June 3, 2022, indicated R1 received assistance with medication administration. R1's electronic medication administration record (eMAR) dated December 1, 2023, through December 22, 2023, lacked a dosage strength for R1's potassium chloride medication to be administered. R1's eMAR indicated potassium chloride powder (for low potassium levels in the blood), dissolve one packet in liquid, and drink once daily. R1's record included signed orders dated May 12, 2023, that included: -potassium chloride 20 milliequivalents (mEq), by mouth, once daily. On February 7, 2024, at 2:52 p.m., during a phone call, clinical nurse supervisor (CNS)-B stated, the potassium chloride missing dosage on the eMAR was transcribed in error. The licensee's Medication Documentation policy dated August 1, 2021, included "Each medication administered by [Licensee] staff will be documented in the resident ' s clinical record. Documentation will be complete, accurate and legible." Additionally, indicated "Complete documentation of medication administration includes the following: a. Resident's name; b. Medication name;	01760		

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01760	Continued From page 25 c. Medication dosage; d. Date and time of administration; e. Method/route of administration; and f. Signature and Title of staff administering the medication." The licensee's Medication Orders policy dated August 1, 2021, included "[Licensee] will administer medications as prescribed by the authorized prescriber and in accordance with all the rights defined in the Home Care Bill of Rights and in the Health Insurance Portability and Accountability Act." Also, indicated "4. When a written or electronic prescription is received, it must be communicated to the registered nurse in charge and recorded or placed into the resident's clinical record." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the required notice be posted at the main entry way of the	03090		

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03090	Continued From page 26 establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all current residents in the assisted living facility, staff, and any visitors to the facility. 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 February 6, 2024, at 10:10 a.m., upon entering the facility, the surveyor observed the one entrance accessible by visitors lacked the required notice for electronic monitoring. On February 6, 2024, at 11:00 a.m., the surveyor observed the facility postings with licensed assisted living director (LALD)-A, and clinical nurse supervisor (CNS)-B. The facility lacked an electronic monitoring posting at the main entry way of the facility. On February 6, 2024, at 11:15 a.m., LALD-A stated she was not aware the verbatim notice of electronic monitoring was required to be posted at the entrance accessible by visitors. Also, LALD-A verbalized she would ensure the required information would be posted at the entrance. The licensee's Electronic Monitoring policy dated August 1, 2021, included "8. [Licensee] will post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices,	03090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37482	A. BUILDING: _____ B. WING _____	02/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLYDIA HOME CARE INC	3904 GERSHWIN AVENUE NORTH OAKDALE, MN 55128

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03090	Continued From page 27 may be present to record persons and activities." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090		

Minnesota Department of Health
Division of Environmental Health, FPLS
PO Box 64975
Saint Paul, 55164-0975
651-201-4500

Type: Full
Date: *02/06/24*
Time: 10:58:41
Report: 1023241024

Food and Beverage Establishment Inspection Report

Location:
Olydia Home Care Inc
3904 Gershwin Avenue North
Oakdale, MN55128
Washington County, 82

Establishment Info:
ID #: 0038784
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6127036144
ID #:

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

The following orders were issued during this inspection.

2-100 Supervision

2-102.12DMN

MN Rule 4626.0033D Post the certified food protection manager certificate.

POST THE CERTIFICATE AT FACILITY.

Comply By: 02/06/24

Surface and Equipment Sanitizers

Chlorine: = at Degrees Fahrenheit
Location:
Violation Issued: No

Hot Water: = at Degrees Fahrenheit
Location: ANSI 184 DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Hold/AIR
Temperature: 39 Degrees Fahrenheit - Location: REACH IN COOLER
Violation Issued: No

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

THIS INSPECTION WAS CONDUCTED IN CONJUNCTION WITH MDH HEALTH REGULATORY DIVISION (HRD) SURVEY. INSPECTION CONDUCTED IN PRESENCE OF THE PERSON IN CHARGE.

THIS FACILITY DOES NOT HAVE ALL COMMERCIAL GRADE ANSI EQUIPMENT. ALL FOOD

MUST BE SERVED THE SAME DAY IT IS PREPARED, AND LEFTOVERS CAN NEVER BE SAVED. FOOD SERVICE IS PROVIDED BY FACILITY STAFF.

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

THESE TOPICS WERE DISCUSSED WITH THE PERSON IN CHARGE:
- EMPLOYEE ILLNESS EXCLUSION
- HAND WASHING PROCEDURE
- NO BARE HAND CONTACT WITH RTE FOOD
- VOMIT CLEAN UP PROCEDURE
- FULLY COOKING FOOD FOR HIGH RISK POPULATIONS
- ANSI 184 DISH WASHER

NO RESIDENTS PRESENT AT TIME OF INSPECTION.

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 1023241024 of 02/06/24.

Certified Food Protection Manager LYDIA NKWONKAM

Certification Number: 109132 Expires: 08/16/24

Inspection report reviewed with person in charge and emailed.

Signed: _____
LYDIA NKWONKAM
PERSON IN CHARGE

Signed: Gregory T Nelson
Gregory T. Nelson
Public Health Sanitarian
Freeman Building
651-201-4259
greg.nelson@state.mn.us